**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18501

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Margaret L. Layton | 6 | 6 | 2002 | 7:50 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2408 Weldon Drive | Westminster | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-22-1909 | 1☐ M 2☒ F | 83 Yrs. | | | Dec. 9, 1918 | Md. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Carroll | Westminster | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2408 Weldon Drive | 21157 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Licensed Practical Nurse | Nursing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frederick L. Will | Lottie Mae Knauff |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Weldon Will/Nephew | 2408 Weldon Drive, Westminster, MD. 21157 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Lake View Memorial Pk. | 6/10/2002 | Sykesville, MD. |

21. Signature of Funeral Service Licensee: Todd Miller

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Esophageal Cancer — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D33681

29d. Date signed (Month, Day, Year): 6/7/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael McElwee 1380 Progress Way Eldersburg, MD 21784

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#25 PER MD. G808 6-10-02 JAB

# Certificate of Death

Reg. No. 2002 18502

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Larry Darnell Manning Jr

2. Date of Death: Month 5 Day 17 Year 2002

3. Time of Death: 5:40 AM

4a. Facility Name (If not institution, give street and number): Mercy Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: N/A

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours 4, Min.

8. Date of Birth (Month, Day, Year): 5/17/2002

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: N/A

10b. County: N/A

10c. City, Town or Location: N/A

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No

10e. Street and Number: N/A

10f. Zip Code: N/A

10g. Citizen of What Country: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Larry Darnell Manning, Jr.

18. Mother's Name (First, Middle, Maiden Surname): Pamela Leak

19a. Informant's Name/Relationship (Type, Print): Pamela Leak/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7102 Rudisill CT Baltimore, MD 21244

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery Date: 05/23/02

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edison H. Perkins

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Extreme Prematurity | 4 hrs |
| Due to (or as a consequence of): | | |
| b. | Respiratory Distress Syndrome | 4 hrs |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. | Pneumothorax | 4 hrs |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Rod Neonatologist

29c. License number: D48175

29d. Date signed (Month, Day, Year): 5/17/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andres Rodriguez, Mercy Medical Center, 301 St Paul Place Balt

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature: Gwen G Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18503

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lorraine M. Miller
2. Date of Death Month: 6 Day: 5 Year: 02
3. Time of Death: 530 AM
4e. Facility Name (If not institution, give street end number): Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Maryland

**Funeral Director**

5. Social Security Number: 214-20-7007
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/8/26
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3300 Benson Ave. Apt. 412
10f. Zip Code: 21227
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Home Maker

17. Father's Name (First, Middle, Last): Leo Collins
18. Mother's Name (First, Middle, Maiden Surname): Matilda Moran

19a. Informant's Name/Relationship (Type, Print): Patricia M. Smith (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 800 Lynch Terrace, Fallston, Md. 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer Cemetery
Date: 6/8/2002
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: John F. Collins
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. TERMINAL CARDIAC ARRHYTHMIA | MINUTES |
| Due to (or as a consequence of): | b. ISCHEMIC CARDIOMYOPATHY | 12 YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. CORONARY ARTERY INSUFFICIENCY | 20 YEARS |
| Due to (or as a consequence of): | d. ARTERIOSCLEROSIS | 25 YEARS |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL INSUFFICIENCY

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph D. Notarangelo M.D.
29c. License number: D07316
29d. Date signed (Month, Day, Year): JUNE 5-2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JOSEPH D. NOTARANGELO M.D. 301 ST. PAUL PLACE BALTIMORE 21202

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18504

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|---|
| Elizabeth | Meiss | June 4, 2002 | 12:57 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St Agnes HealthCare | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | If Under 1 Year: Days | If Under 24 Hrs.: Hours | If Under 24 Hrs.: Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 208-24-2862 | 1☐M 2☒F | 72 Yrs. | | | | | Jan. 1, 1930 | PA. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Baltimore | Baltimore | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6215 Frederick Rd. | 21228 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | homemaker | own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Conrad Walters | Elizabeth F. Altomiller |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Loreen K. Doyle | 46 Tudor Ct., Timonium, Md. 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Baltimore/Wash. Crem. | 6-8-02 | Laurel, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Juanita R Thomas | Witzke Funeral Home, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Adult Respiratory Distress Syndrome Due to (or as a consequence of): | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Pneumonia Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Atrial fibrilation

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ S Yousif, M.D. | 13133 | June 4, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SOHAIR YOUSIF 900 Caton Ave Baltimore, MD 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 10 2002 | B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME MEISS, ELIZABETH

20

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18505

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| PATSY NUTT | JUNE 4 2002 | 7:30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| BON SECOURS HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-82-9123 | 1☐M 2☒F | 35 Yrs. | | | 12/03/66 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1729 ASHBURTON ST | 21216 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | N/A | N/A |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JAMES NUTT SR. | ETHEL LOUDEN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JAMES NUTT JR, BROTHER | 1311 N. FULTON ST, BAKTO, MD 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | METRO CREMATORY | 6-10-02 | MARYLAND |

21. Signature of Funeral Service Licensee: Willie Edwards

22. Name and Address of Facility: 4600 LIBERTY HGHTS AVE, 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):
b. End Stage Renal Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hyper tension

Due to (or as a consequence of):
d. Pulmonary Edema

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☒Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Terance J. Lamb M.D. | D37203 | JUNE 4 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TERANCE L. LAMB M.D. BONSECOURS HOSPITAL, BALT, MD.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 10 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No 2002 18596

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ozbenian

2. Date of Death: Month May Day 22 Year 2002

3. Time of Death: 2133 P.M

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hosp.

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: none

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 0 Yrs. | If Under 1 Year: Months 0 Days 0 | If Under 24 Hrs.: Hours 4 Min. 51

8. Date of Birth (Month, Day, Year): May 22, 2002

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 808 Elmcroft Blud.

10f. Zip Code: 20850

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 0 College (1-4or 5+) 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): infant

16b. Kind of Business/Industry: infant

17. Father's Name (First, Middle, Last): Janser John Ozbenian

18. Mother's Name (First, Middle, Maiden Surname): Jacqueline Albert Jerikdjian

19a. Informant's Name/Relationship (Type, Print): Parents Janser and Jacqueline

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 808 Elmcroft Blud. Rockville, MD 20850

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Stericycle

Date: June 22, 2002

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature] 29 May 02

22. Name and Address of Facility: Shady Grove Adventist Hospital 9901 Med. Center Dr. Rockville, MD

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiorgan system failure — 5hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Extreme prematurity, 17 week fetus — 5hrs

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year — May 22, 2002

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A Kimberly Iafolla MD

29c. License number: D50902

29d. Date signed (Month, Day, Year): May 22, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A Kimberly Iafolla, MD 9901 Med Center Drive Rockville, MD 20850

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
WALTER PERRY
02-2885-510

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEMS 323,PII &27 PER ME. G809 7/17/02 JH

# Certificate of Death

Reg. No. 2002 18507

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WALTER THOMAS PERRY
2. Date of Death: Month JUNE Day 1, Year 2002
3. Time of Death: 1842 PM
4a. Facility Name (If not institution, give street and number): SARATOGA & DAVIS STREETS
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 217-40-8679
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 08, 1943
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HOWARD
10c. City, Town or Location: COLUMBIA
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6192 GREENBLADE GARTH
10f. Zip Code: 21045
10g. Citizen of What Country? USA.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CASHIER
16b. Kind of Business/Industry: GAS STATION

17. Father's Name (First, Middle, Last): JAMES PERRY
18. Mother's Name (First, Middle, Maiden Surname): ELSIE ALLEN

19a. Informant's Name/Relationship (Type, Print): LINDA PERRY (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6192 GREENBLADE GARTH, COLUMBIA, MD. 21045

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY
Date: 06-07-02
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2948 N. FULTON AVE., BALTO. MD. 21217

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. CIRRHOSIS OF LIVER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
NARCOTISM

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): JUNE 2, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARGARITA A. KOROL 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #1 PER PHY G808 6/10/02 CH — Certificate of Death — Reg. No. 2002 18508

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ~~Richard H. Parnes~~ RICHARD R. PARNES
2. Date of Death: Month 06 Day 03 Year 2002
3. Time of Death: 8:27P M
4a. Facility Name (If not institution, give street and number): University of Maryland Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 147-38-3546
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 55 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 15 1946
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1303 Linden Green
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): +4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bartender
16b. Kind of Business/Industry: Service Industry
17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): Rose unknown
19a. Informant's Name/Relationship (Type, Print): Linda Fronzoli (Executor)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1689 Windy Hill Road, New Freedom, Penna. 17349
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory Date: 5/04/2002
20c. Location - City or Town, State: Baltimore, Md.
21. Signature of Funeral Service Licensee: M00922
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. pneumonia — Approximate Interval Between Onset and Death: 5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
(1) HIV
(2) laryngeal cell cancer

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: A. M Giltner MD
29c. License number: P14698
29d. Date signed (Month, Day, Year): 06/03/2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Aaron M. Giltner, M.D. 22 So. Greene St., Baltimore, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM #7 PER FH G8086/10/02 JH

Reg. No. 2002 18509

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Arthur | Everitt | Peltosalo | June 7, 2002 | 2:50 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 650 Oxbury Road | Gibson Island | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 316-20-7908 | 1☐M 2☐F XX | 80 Yrs. | | | May 2, 1922 | Hartford Conn. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Anne Arundel | Gibson Island | 1☐Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 650 Oxbury Road | 21056 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☐No If Yes, Give Year or Dates: 43-45 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Executive | General Electric |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Arthur Edward Peltosalo | Elsa Wallenius |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lavinia Peltosalo Wife | P.O. Box 87 Gibson Island, MD 21056 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Crematory | 6-8-02 | Baltimore, MD |

21. Signature of Funeral Service Licensee: Patrick J. Hardesty

22. Name and Address of Facility: Hardesty Funeral Home P.A. 12 RIDGELY AVE ANN MD 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PROSTATE CANCER | SEVEN YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D52245 | JUNE 8, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL FREEDMAN, MD 205 RIDGELY AVENUE ANNAPOLIS, MARYLAND 21401

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 10 2002 | Lynn B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18510

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Calvin John Pfeiffer

2. Date of Death (Month, Day, Year): June 6, 2002

3. Time of Death: 6:45a M

4a. Facility Name (If not institution, give street and number): Catonsville Commons

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-24-8498

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7/2/1928

9. Birthplace (State or Foreign Country): MD.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3529 Milford Mill Rd.

10f. Zip Code: 21244

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): printer

16b. Kind of Business/Industry: printing

17. Father's Name (First, Middle, Last): Edward Pfeiffer

18. Mother's Name (First, Middle, Maiden Surname): Katherine Scheidt

19a. Informant's Name/Relationship (Type, Print): Stephen Trust, cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 42 Pepperdine Circle, Catonsville, Md. 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cem.

Date: 6/10/02

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ Handa L Lemmer

22. Name and Address of Facility: Witzke Funeral Home of Catonsville Inc. 1630 Edmondson Avenue, Catonsville, Md. 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Hypernephroma

Due to (or as a consequence of):

d. Pneumonia

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ PHYSICIAN

29c. License number: D 57543

29d. Date signed (Month, Day, Year): 6-6-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. SANDHU, MD 3007 E, NORTHERN PKWY, BALTIMORE, MD 21210

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature: Donna G Sparks

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ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other then "natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Exeminer must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18511

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Sara Irene Craig Herchenrider Roberts | June 4 2002 | 8:00 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2001 Warners Terrace, North, #104 | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 201-26-1487 | 1☐M 2☒F | 66 Yrs. | | | Nov. 20, 1935 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Annapolis | ☒1 Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2001 Warners Terrace, N., #104 | 21401 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes ☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Howard Craig | Evalyn Scott |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Holly Moreland (Daughter) | 142 Idlewild Road, Severna Park, MD 21146 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Metro Crematory | 6/10/2002 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Patrick A. Hardesty | Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Small cell lung cancer | 3 weeks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Jeanine Werner MD | D52830 | June 5, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jeanine Werner MD 900 Bestgate Road, #300, Annapolis, MD 21401

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 10 2002 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18512

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| PATRICIA M. REES | May 29, 2002 | 1:45 PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 10209 Cape Ann Drive | Columbia | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 570-48-7524 | 1 ☐ M 2 ☒ F | 63 Yrs. | | | Jan. 1. 1939 | CA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Howard | Columbia | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10209 Cape Ann Drive | 21046 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 5+ | teacher | education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Alvin Carson Stauffer | Thelma Waterman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Charles A. Rees/spouse | 10209 Cape Ann Drive, Columbia, MD 21046 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Joseph B. Van Sant | State Anatomy Board, 655 W. Baltimore Street, Baltimore, Maryland 21201 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. metastatic Colon Cancer | 12 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
☒ 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D 41139 | June, 3rd, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
11065 Little Patuxent Parkway, Columbia, MD 21045

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 10 2002 | [signature] |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM #18 PER FH G808 6/10/02 JH

Reg. No. 2002 18513

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROBERT ROCKLIN

2. Date of Death Month: JUNE Day: 5TH Year: 2002

3. Time of Death: 10.10 P M

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 565-18-2569

6. Sex: 1 XX M 2 ☐ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 13, 1916

9. Birthplace (State or Foreign Country): CA

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☐ Yes XX No

10e. Street and Number: 9209 HOWARD SQUARE DRIVE

10f. Zip Code: 21208

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): AUDITOR

16b. Kind of Business/Industry: HEALTH NAT'L INSTITUTE OF

17. Father's Name (First, Middle, Last): ALTER ROCKLIN

18. Mother's Name (First, Middle, Maiden Surname): ~~(UNKNOWN)~~ MINNIE ORLIJAN

19a. Informant's Name/Relationship (Type, Print): E.T. ROCKLIN / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9209 HOWARD SQUARE DRIVE - BALTIMORE, MD 21208

20a. Method of Disposition: 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HILLTOP SERVICE CORP.

Date: 6/7/2002

20c. Location - City or Town, State: TOWSON, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joginder P Mehta M.D

29c. License number: D 0041410

29d. Date signed (Month, Day, Year): June 5th, 2002.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P MEHTA NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133.

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature: ▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18514

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| SALLY | ROSENTHAL | JUNE 6, 2002 | 8:46 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| BRIGHTWOOD MERIDIAN NURSING CENTER | LUTHERVILLE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-01-1852 | 1 ☐ M 2 ☒ F | 88 Yrs. | | | FEB. 25, 1914 | W.V. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 16 HALCYON COURT | 21208 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 4 | OWNER | FURNITURE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| HARRY SELIGMAN | MOLLY SHOR |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| SIMA BLUE / DAUGHTER | 16 HALCYON COURT - BALTIMORE, MD 21208 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | BALTIMORE HEBREW CEM | 6/7/2002 | REISTERSTOWN, MD |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure — 5 years

Due to (or as a consequence of):
b. Coronary artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D18095 | 6-6-02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael T Rudloff 1838 Greenspring Rd Suite 300 Balto MD 21208

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 10 2002 | ▶ [signature] B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item 23a, per Dr.,G808,06/10/02dhb

# Certificate of Death

Reg. No. 2002 18515

**Physician /Medical Examiner**

1. Decedent's Nama (First, Middle, Last): JAMES SMITH

2. Data of Death Month: May Day: 29th Yaar: 2002

3. Tima of Death: 6:40 AM

4a Facility Name (If not institution, giva street and number): Hammonds Lane Nursing Center.

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Ann Arundel.

**Funeral Director**

5. Social Sacurity Numbar: 216-50-1141

6. Sax: 1☒ M 2☐ F

7. Aga (In yrs, last birthday): 53 Yrs. | If Undar 1 Year: Months / Days | If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): MAY 31, 1948

9. Birthplaca (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. Stata: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 900 SEAGULL AVENUE

10f. Zip Coda: 21225

10g. Citizan of What Country?: USA.

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decadant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amaricen Indian, Black, Whita, etc. Specify: BLACK

15. Dacedant's Educetion (Spacify only highast greda complatad): Elamentary/Secondary (0-12): 12TH GRADE | Collega (1-4or 5+):

16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use ratired): INSULATOR

16b. Kind of Business/Industry: COLT INSULATION

17. Fathar's Nama (First, Middla, Last): JAMES SMITH SR.

18. Mothar's Nama (First, Middla, Maidan Surnama): NORMA CHARLOTTE TWYMAN

19a. Informant's Name/Relationship (Type, Print): JANICE HARRISON (STEP-DAUGHTER)

19b. Mailing Address (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda): 2076 ASHLAND AVE., BALTIMORE, MD. 21205

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cametery, crametory or othar placa): ARBUTUS CEMETERY

Date: 6-3-02

20c. Location - City or Town, Stata: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Robert N. Willis

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTO, MD. 21217

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not anter tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only ona causa on each lina.

Approximata Intarval Batween Onsat and Death

Immediata Cause (Final disaasa or condition resulting in daath): a. ASPIRATION Pneumonia

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immediata ceuse. Entar Undarlying Ceuse (Disaasa or injury that initiated avants resulting in daath) Last:

b. CEREBROVASCULAR ACCIDENT — 1 MONTH

Due to (or es a consequance of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha undarlying cause given in Part I.

DIABETES MELLITUS.

HYPERTENSION

23b. Did tobacco usa contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy parformed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Yaar)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurrad at the tima, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner statad.

29b. Signatura and titla of certifiar

29c. Licansa number: D51596

29d. Date signed (Month, Dey, Year): May 29th 2002

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): K. AMBALAVANAR. 716 MAIDEN CHOICE LANE LL1, CATONSVILLE, MD 21228

**State Registrar**

31. Data filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signatura: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18516

11:27AM 6/7/02 Eugene Strine

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Eugene Edwin Strine | June 7, 2002 | 11:27 a.m. |

| 4a Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Gilchrist Center | Towson | Baltimore Co. |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-52-8579 | 1☒M 2☐F | 53 Yrs. | | | Jan. 23, 1949 | New Windsor, Marylan |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore Co. | Perry Hall | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6 Brantwood Court | 21236 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: Vietnam | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 yrs. | | Postal Clerk | U.S. Postal Service |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Donald Edwin Strine | Betty Mae Wagner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Barbara Strine / wife | 6 Brantwood Court Baltimore, Maryland 21236 |

| 20a. Method of Disposition | 20b. Place of Disposition (Neme of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Hilltop Service Corp. | 6/10/2002 | Towson, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael E. Canapp | Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ORA-pharyngeal CANCER | months |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☒**Yes** 2☐**No** 3☐**Probably** 4☐**Unknown**

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M Anthony Riley, MD | 025205 | June 7, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W.A. Riley GBMC 6701 N. Charles St. Baltimore, Md 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 10 2002 | ▶ Brenda G Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6+1

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18517

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| DOUGLAS E. SCHROEDER | June 3, 2002 | 9:25 AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2929 Kidds School House Road | Parkton | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-42-5268 | 1☒M 2☐F | 58 Yrs. | | | Sept. 13, 1943 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Parkton | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2929 Kidds School House Road | 21120 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1964-70 | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | self employed | owner-bar/restaurant |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Maurice Schroeder | Margaret Froehlinger |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Paul Schroeder/brother | 1312 Monkton Rd., Monkton, MD 21111 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☒Donation 5☐Other (Specify) | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Joseph E. Van Sant | State Anatomy Board, 655 W. Baltimore Street, Baltimore, MD 21201 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Brain metastasis

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☑No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Albert F. DeCesley MD | D23829 | 6/4/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Albert F DeCesley MD 515 Fairmount Ave Towson, Md 21286

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 10 2002 | B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18518

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Dete of Deeth Month / Dey / Year | 3. Time of Death |
|---|---|---|---|---|
| Mary G. Snively | | | June 7, 2002 | 7:00 am |
| 4a. Fecility Neme (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | | |
| Good Samaritan Nursing Center | Baltimore | n/a | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. lest birthday) | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-24-4668 | 1☐M 2☒F | 90 Yrs. | | | April 12, 1912 | West Virginia |

Usuel Residence of Decedent

| 10a. Stete | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | n/a | Baltimore | 1☒Yes 2☐No |

| 10e. Street end Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2904 E. Northern Parkway | 21214 | USA |

| 11. Meritel Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Merried 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Yeer or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | n/a | Homemaker | Own home |

| 17. Fether's Neme (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Stelatt | Margaret Ladanyi |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Doris P. Duvall-cousin | 3905 Darleigh Rd., Unit 2E, Baltimore, MD 21236 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Hilltop Service Corporation | 6/8/02 | Towson, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ William G. Dau | Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214 |

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Vascular Dementia | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last | b. | |
| | Due to (or es a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

| 24a. Was en autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Menner of Deeth | 28e. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) |

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner steted.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D0039297 | 6/7/02 |

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)
MICHAEL K. RO, MD 2314 E. JOPPA RD. BALTIMORE MD 21234

**State Registrar**

| 31. Dete filed (Month, Day, Year) | 32. Registrer's Signature |
|---|---|
| JUN 10 2002 | [signature] |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

Amend Items 24a, 25, 27, 29a, per Dr, G808, 06/10/02dhb — For State Registrar

# State of Maryland / Department of Health and Mental Hygiene
## Certificate of Death

Reg. No. 2002 18519

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| MICHAEL THOMAS STROW | JUNE 4 2002 | 7:00 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 4817 Bayonne Avenue | Baltimore City | Baltimore City |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-36-3362 | X 1 M 2 F | 63 Yrs. | | | Aug. 28, 1938 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore City | Baltimore City | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4817 Bayonne Avenue | 21206 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 Widowed X Divorced | X Yes 2 No If Yes, Give Year or Dates: Unknown | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 yrs. | N/A | Truck Driver | Potts & Callahan |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Edward L. Strow | Lydia Arsenault |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patrick N. Strow (Brother) | 528 Packing House Rd. Hanover, Pa. 17331 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Metro Crematory Inc. | 6-4-02 | Baltimore, Md. |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lassahn Funeral Home, 7401 Belair Rd. Baltimore, Md. 21236

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. MYOCARDIAL INFARCTION | SAME |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 X No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 Yes 2 X No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA — Other: 4 Nursing Home 5 ✓ Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D01373 | 6-5-02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS X. CARMODY, M.D. 7505 OSLER DR. #212 TOWSON, MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 10 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

02-3029-510

mnmr

ISAAC SALLEY Amend Item#1 perMEOG809 7/8/02 EW

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18520

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ~~Issac Salley~~ Isaac Salley

2. Date of Death: Month June, Day 06, Year 2002

3. Time of Death: 11:34

4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 249-50-3464

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Oct. 10, 1932

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2008 Kennedy Avenue

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Crane Operator

16b. Kind of Business/Industry: Salvage

17. Father's Name (First, Middle, Last): Bill Salley

18. Mother's Name (First, Middle, Maiden Surname): Eller Corley

19a. Informant's Name/Relationship (Type, Print): Cynthia Richardson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2008 Kennedy Ave, Baltimore, Md 21218

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: Jun 15, 02

20c. Location - City or Town, State: Balto. MD

21. Signature of Funeral Service Licensee: Ronald A Grayson

22. Name and Address of Facility: Ronald A. Grayson Funeral Service, 8312 Liberty Road, Balto., MD, 21244

**Physician Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end manner es stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: A Kelly MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Dey, Year): JUNE 07, 2002

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Susan Hogan, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Dete filed (Month, Day, Year): JUN 10 2002

32. Registrer's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18521

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret Shirley Smeltzer

2. Date of Death (Month, Day, Year): June 5 2002

3. Time of Death: 3:30 PM

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-30-3683

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2/14/1936

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Overlea

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6205 Marglenn Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lunch Worker

16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Joseph Hummel

18. Mother's Name (First, Middle, Maiden Surname): Margaret Huber

19a. Informant's Name/Relationship (Type, Print): Elwood Smeltzer/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6205 Marglen Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill

Date: 6/8/02

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Colon Cancer To Liver

Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? M 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D 37612

29d. Date signed (Month, Day, Year): June 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Mohamad Alabrash 9000 Franklin Square Dr. Baltimore Md 21237

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature

**To Be Completed by Funeral Director**

Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18522

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| ELIHUE | STEELMAN | 06 / 01 / 2002 | 1549 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical System | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-50-1531 | 1☒M 2☐F | 53 Yrs. | | | Aug. 19, 1948 | Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒Yes 2☐No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4211 Kenwood Avenue | 21206 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8th. Grade | | Maintainence Supervisor | Management Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Elihue Jackson Steelman | Clara Barker |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Claire Potter/Friend | 4211 Kenwood Avenue Baltimore MD 21206 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Balto/Wash Crematory | 06/10/2002 | Laurel MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore MD 21206 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☒Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ K Hairston MD | G 15877 | 06/07/2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kristen G. Hairston 22 South Green Street Baltimore

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 10 2002 | Dawn B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

VOID

certificate no.
2002-18523

SEE

certificate no.
XXXXXX

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #10e PER FH G808 6/10/02 JH

# Certificate of Death

Reg. No 2002 18524

George Williams
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GEORGE WILLIAMS
2. Date of Death (Month, Day, Year): June 7, 2002
3. Time of Death: 4.13 A M
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 243-10-7503
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 04-03-1917
9. Birthplace (State or Foreign Country): WAYNE, NC

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: ~~2710~~ 2719 ELLICOTT DRIVEWAY
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MINISTER
16b. Kind of Business/Industry: MINISTERIAL

17. Father's Name (First, Middle, Last): GEORGE WILLIAMS
18. Mother's Name (First, Middle, Maiden Surname): CECILA WILLIAMS

19a. Informant's Name/Relationship (Type, Print): ALICE WILLIAMS, DORETHA DUBOSE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2719 ELLICOTT DRWY, BALTIMORE, MD 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN
Date: 6-15-02
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: Willie E Howell
22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Acute Renal Failure | 6 Days |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | Congestive Heart Failure | 4 years |
| Due to (or as a consequence of): | | |
| c. | Hypertension | 4 years |
| Due to (or as a consequence of): | | |
| d. | | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Staphylococcal Sepsis
Diabetes Mellitus
Asbestosis

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D 31076
29d. Date signed (Month, Day, Year): June, 7, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Orn Eliasson 9000 Franklin Square Drive Baltimore, MD. 21237

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18525

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JACK ZIMMERMAN
2. Date of Death: Month JUNE Day 06 Year 2002
3. Time of Death: 12:45 PM
4a. Facility Name (If not institution, give street and number): BALTIMORE VA MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: 213-26-8900
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUGUST 09, 1930
9. Birthplace (State or Foreign Country):

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1820 Spence Street Apt. 212
10f. Zip Code: 21230
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Commercial Construction

17. Father's Name (First, Middle, Last): Von Zimmerman
18. Mother's Name (First, Middle, Maiden Surname): Ruth Worthington

19a. Informant's Name/Relationship (Type, Print): Eugene Zimmerman Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 150 Howard Ave., Lansdowne, MD 21227

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lakeview Memorial Park
Date: 6-10-2002
20c. Location - City or Town, State: Randallstown, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PNEUMONIA | |
| Due to (or as a consequence of): | b. HODGKIN'S DISEASE | 6 MONTHS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Polk MD
29c. License number: P15807
29d. Date signed (Month, Day, Year): JUNE 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTOPHER POLK 22 SOUTH GREENE ST, DEPT OF MEDICINE BALTIMORE, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Amended#23perMD FCHD,KS 05/28/02** *Certificate of Death* Reg. No. 2002 18526

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAISY AENOLS
2. Date of Death Month: 5 Day: 24 Year: 2002
3. Time of Death: 1232 am
4a. Facility Name (If not institution, give street and number): Lorien Nursing Home
4b. City, Town, or Location of Death: Mt. Airy
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 246-09-5279
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey) Yrs.: 81
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): 03-25-1921
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Mt. Airy
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 12512 Lee Hill Drive
10f. Zip Code: 21771
10g. Citizen of Whet Country?: United States
11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 7 / College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Hairdresser
16b. Kind of Business/Industry: Service
17. Father's Neme (First, Middle, Last): Collie White
18. Mother's Name (First, Middle, Maiden Surname): Ola Arnette
19a. Informant's Name/Relationship (Type, Print): Iris Lehman/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4730 S Reyburn Court, Mt. Airy, Maryland 21771
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Frederick Crematory, INC
Date: 5-24-2002
20c. Location - City or Town, State: Frederick, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure, Pneumonia — 1 month

Due to (or as a consequence of):
b. Lung Cancer — 1 month

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Pneumonia

Due to (or as e consequence of):
d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did **tobacco use contribute to the cause** of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours eftar death.
To the Funeral Director: After this certificeta has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be datached for use es the burial-transit

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of cartifier: [signature] MD
29c. License number: D0053150
29d. Date signed (Month, Day, Yeer): 5/24/02

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): Shakunmala Gupta, M.D. 713 Midway Ave, Mt. Airy, MD 21771

State Registrar

31. Dete filed (Month, Day, Year): MAY 28 2002
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18527

Mary Anderson, I

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Mary Irene Anderson | May 19 2002 | 9:15 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| North Arundel Hospital | Glen Burnie | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-03-5688 | 1☐M 2☒F | 94 Yrs. | | | Nov. 24, 1907 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Severna Park | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 304 Balsam Drive | 21146 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Cafeteria Manager | Cafeteria Management |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Warner | Irene Vogt |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dawn Barnett/Granddaughter | 334 Sweet Briar Court, Joppatown, MD 21085 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Lorraine Park | May 22, 2002 | Baltimore, MD |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cerebero - vascular Accident | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Hypertension | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Zeleke Icassawn, M.D | D0055973 | MAY 19, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Zeleke Desse 11200 Lockwood dr Silver Spring, MD 20901

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 21 2002 | [signature] |

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18528

APPLETON, JOHN

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John Michael Appleton

2. Date of Death — Month: MAY Day: 20 Year: 2002

3. Time of Death: 1:15 PM

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 218-14-3415

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Yeer): Jul. 7, 1925

9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 404 Pasadena Road

10f. Zip Code: 21122

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Letter Carrier

16b. Kind of Business/Industry: US Post Office

17. Father's Name (First, Middle, Last): John Michael Appleton

18. Mother's Name (First, Middle, Maiden Surname): Mary Jenkins

19a. Informant's Name/Relationship (Type, Print): John M. Appleton, III/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 406 Pasadena Road, Pasadena, MD 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Cemetery

Date: May 23, 2002

20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD

29c. License number: D48006

29d. Date signed (Month, Day, Year): May 20th, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI BOAITEY, 301 Hospital Dr, Glen Burnie, MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): MAY 21 2002

32. Registrar's Signature: [signature]

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

DHMH 17 Rev 1/2001

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 | 8529

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: HELEN MAE ALVIS
2. Date of Death Month / Day / Year: MAY 21, 2002
3. Time of Death: 10:25 PM
4a. Facility Name *(If not institution, give street and number)*: KENT & QUEEN ANNE HOSPITAL
4b. City, Town, or Location of Death: CHESTERTOWN
4c. County of Death: KENT

**Funeral Director**

5. Social Security Number: 216-42-3373
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: DEC. 2, 1927
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7166 LAUREN LANE
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 | College (1-4or 5+): -0-
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: JOHN LOUIS HENDERSON
18. Mother's Name *(First, Middle, Maiden Surname)*: HELEN POLLY DORSEY

19a. Informant's Name/Relationship *(Type, Print)*: MARY CARSON / DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 210 COCKEY LANE, STEVENSVILE, MD 21666

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SPRING HILL CEMETERY
Date: 5-24-2002
20c. Location - City or Town, State: EASTON, MD 21601

21. Signature of Funeral Service Licensee: Ryan P Mulkin
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Ischemic Cardiomyopathy
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death: 3M

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* _____ 9☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: G Sprouse
29c. License number: D32036
29d. Date signed *(Month, Day, Year)*: 5/22/2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary Sprouse 2108 DiDonato Drive Chester MD 21619

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 23 2002
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2002 18530

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Charlotte Bussard Bowers | May 26, 2002 | 10 P. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Frederick Memorial Hospital | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-44-2922 | 1☐M 2☒F | 100 Yrs. | | | July 12, 1901 | MD. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Frederick | Middletown | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15 Locust Blvd. | 21769 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No *Specify:* | *Specify:* White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | homemaker | own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Samuel David Bussard | Catherine Rebecca Summers |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Charlotte Warrenfeltz (Daughter) | 15 Locust Blvd., Middletown, MD. 21769 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Lutheran Cemetery | 5/30/02 | Middletown, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Donald B. Thompson Funeral Home 31 E. main St., Middletown, MD. 21769 |

**Physician /Medical Examiner**

23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. colon Cancer | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D43780 | 5/29/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kevin E. Holland 300 S. Church St. Middletown MD 21769

25

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18531

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): NOVYCE A. BARNES
2. Date of Death (Month, Day, Year): MAY 15, 2002
3. Time of Death: 7:30A M
4a. Facility Name (If not institution, give street and number): 3476 VICKSBURG DRIVE
4b. City, Town, or Location of Death: DAVIDSONVILLE
4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 259 40 4994
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC.12,1930
9. Birthplace (State or Foreign Country): GEORGIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: DAVIDSONVILLE
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 3476 VICKSBURG DRIVE
10f. Zip Code: 21035
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RESTAURANT WORKER
16b. Kind of Business/Industry: FOOD INDUSTRY

17. Father's Name (First, Middle, Last): GUS COOT YOUNG
18. Mother's Name (First, Middle, Maiden Surname): BERLEY WARD

19a. Informant's Name/Relationship (Type, Print): YVONNE M. RIDGEWAY (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3476 VICKSBURG DR. DAVIDSONVILLE,MD. 21035

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LAKEMONT CEMETERY
Date: 05-17-02
20c. Location - City or Town, State: DAVIDSONVILLE,MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER,MD. 21037

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. metastatic cancer to lung — Approximate Interval Between Onset and Death: 4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Breast cancer — 4 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D52830
29d. Date signed (Month, Day, Year): May 15, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeanine Werner, 900 Bestgate Road #300, Annapolis, MD 21401

**State Registrar**

31. Date filed (Month, Day, Year): MAY 16 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For Stete Registrar

Reg. No. 2002 18532

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Theodore A. Bucolo
2. Date of Death (Month, Day, Year): May 19, 2002
3. Time of Death: 11:45 A M
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 578-48-7195
6. Sex: 1 ☐ M 2 ☐ F — XX
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 2, 1935
9. Birthplace (State or Foreign Country): Washington, D.C.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3768 Colliers Drive
10f. Zip Code: 21037
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1961-62
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator
16b. Kind of Business/Industry: Printing Company

17. Father's Name (First, Middle, Last): Joseph Bucolo
18. Mother's Name (First, Middle, Maiden Surname): Grace Mary Caruso

19a. Informant's Name/Relationship (Type, Print): Marie G. Bucolo/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3768 Colliers Drive Edgewater, Maryland 21037

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Hillcrest Cemetery
Date: 5-22-02
20c. Location - City or Town, State: Annapolis, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Cerebral vascular Accidents — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. Tobacco abuse — years
Due to (or as a consequence of): c. Diabetes mellitus — years
Due to (or as a consequence of): d. HTN (Hypertension) — years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypercholesterolemia

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D58724
29d. Date signed (Month, Day, Year): 05/20/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALISON BARTFIELD AAMC 2001 MEDICAL PKWY ANNAP, MD21401

**State Registrar**

31. Date filed (Month, Day, Year): MAY 21 2002
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18533

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Rita S. Brainard
2. Date of Death: Month: May; Day: 22; Year: 2002
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 279-28-9554
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 30, 1911
9. Birthplace (State or Foreign Country): Ohio

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 539 Corbin Parkway
10f. Zip Code: 21401
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Hal Spefford
18. Mother's Name (First, Middle, Maiden Surname): Viva Wood

19a. Informant's Name/Relationship (Type, Print): Jerry Brainard/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 539 Corbin Parkway Annapolis, MD 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Crematory
Date: 5/23/2002
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Todd E. Miller
22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 3 weeks

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Christopher Rosberg MD
29c. License number: D0053064
29d. Date signed (Month, Day, Year): 5-22-02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Rosberg MD, AAMC Infectious, Annapolis MD 21401

**State Registrar**

31. Date filed (Month, Day, Year): MAY 23 2002
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18534

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thomas Frederick Bates
2. Date of Death (Month, Day, Year): May 21, 2002
3. Time of Death: 1:30 a M
4a. Facility Name (If not institution, give street and number): 233 Via Dante
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 185-30-1024
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 7, 1938
9. Birthplace (State or Foreign Country): PA

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 233 Via Dante
10f. Zip Code: 21012
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Asst. Athletic Director
16b. Kind of Business/Industry: Collegiate Athletics

17. Father's Name (First, Middle, Last): Arthur L. Bates
18. Mother's Name (First, Middle, Maiden Surname): Mary Jane Kiebort

19a. Informant's Name/Relationship (Type, Print): Barbara A. Bates/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 233 Via Dante, Arnold, MD 21012

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: May 23, 2002
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. metastatic renal cell cancer — Approximate Interval: 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D38158
29d. Date signed (Month, Day, Year): 5/21/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LISA A. DiMarzio MD, 2003 Medical Parkway, Ste 100, Annapolis MD 21401

**State Registrar**

31. Date filed (Month, Day, Year): MAY 24 2002
32. Registrar's Signature: [signature]

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#24a perVERBALG808 6/7/02 EW

# Certificate of Death

Reg. No. 2002 18535

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): SADIE BUSBEE

2. Dete of Deeth: Month 05 Dey 23 Yeer 2002

3. Time of Death: 12 10 PM

4e Feclity Name (If not institution, give street and number): ALICE MANOR NH 2095 Rockrose Av.

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth:

**Funeral Director**

5. Social Security Number: 079-28-1301

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): 4-9-1910

9. Birthplace (State or Foreign Country): Virginia

Usuel Residence of Decedent

10e. Stete: MD

10b. County:

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street and Number: 3333 Alto Road

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Home Maker

16b. Kind of Business/Industry: House

17. Fether's Neme (First, Middle, Last): James Moody

18. Mother's Name (First, Middle, Maiden Sumame): Sarah Green

19a. Informant's Name/Reletionship (Type, Print): Andrew Moody - Son

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 5440 Nelson Avenue, Baltimore MD 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Laurel Hill Baptist

Date: 5-30-02

20c. Location - City or Town, State: Mineral, Virginia

21. Signature of Funeral Service Licensee: John E. Thomasson

22. Name and Address of Feclity: Thomasson's Funeral service PO Box 512 Louisa VA 23093

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Adenocarcinoma of the Colon — mo-years

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ No 3☐ **Probably** 4☐ **Unknown**

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kennita R Cart MD

29c. License number: D0053945

29d. Date signed (Month, Day, Yeer): 5/23/2002

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Kennita R. Carter MD 2095 Rockrose Ave. Baltimore MD 21211

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrer's Signature: Brenda B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#23a perPHYg808 6/7/02 EW **Certificate of Death**

Reg. No. 2002 18536

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): RAYMOND A. BROWN, JR.

2. Date of Death: Month MARCH Day 27 Year 2002

3. Time of Death: 12:55 PM

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center 2001 Medical Parkway Annapolis Md 21403

4b. City, Town, or Location of Death: ANNAPOLIS, MARYLAND

4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 216-22-3595

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 30, 1927

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 964 Spa Road

10f. Zip Code: 21403

10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Produce Manager

16b. Kind of Business/Industry: Produce Market

17. Father's Name (First, Middle, Last): Raymond A. Brown, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Hester Ellen Boyd

19a. Informant's Name/Relationship (Type, Print): Alice Ellen Higgs / sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 964 Spa Road Annapolis, Md. 21403

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Bluff Cemetery

Date: 4-1-2002

20c. Location - City or Town, State: Annapolis, Md.

21. Signature of Funeral Service Licensee: ▶ Brian Powell

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ~~Pneumonia~~ ASPIRATION PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. ~~Aspiration~~ DEMENTIA
Due to (or as a consequence of):
c. ~~Dementia~~
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
a. 1 week
b. 5-10 Yrs ~~1 month~~
c. ~~5-10 years~~

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dehydration
hypernatremia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one) Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature], M.D.

29c. License number: D0056568

29d. Date signed (Month, Day, Year): MARCH 27, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Titus Abraham, M.D. Anne Arundel Medical Center 2001 Medical Parkway Annapolis, Md 21403

**State Registrar**

31. Date filed (Month, Day, Year): MAR 29 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

A.A 039

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18537

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Beryl Eileen Cressman | May 28, 2002 | 2:25 PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Genesis Eldercare Center | La Plata | Charles |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 177-16-5527 | 1☐M 2☒F | 89 Yrs. | | | July 4, 1912 | Pennsylvania |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | CHARLES | WALDORF | 1☐Yes ☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1314 HARWICH DR. | 20601 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4 | BUSINESS MANAGER | REAL ESTATE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| HOMER WILLIAM WATTS | CATHERINE ESTELLA STRAUSS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MARY ELLEN WILMOTH - DAUGHTER | 1314 HARWICH DR. WALDORF, MD 20601 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | NEWTON HAMILTON CEMETERY | 05-31-02 | NEWTON HAMILTON, PA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Mark J. Buhman | Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Coronary artery disease

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerebral Vascular Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) ☒1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Michael Leatherwood, MD | D0021031 | 5/29/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Michael A. Leatherwood, 12070 Old Line Center, #202, Waldorf, MD 20602

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | Geneva G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item#23a perPHYG808 6/7/02 EW

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18538

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Dorothy Cullins Cheseldine | April 20, 2002 | 1:40 p.m. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Mary's Hospital | Leonardtown | St. Mary's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-16-9171 | 1☐ M 2☒ F | 77 Yrs. | | | August 2, 1924 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | St. Mary's | Bushwood | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 37240 Gibson Road | 20618 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Publication & Printing | U.S. Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Russell Cullins | Margaret Mary Hayden |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jerry W. Cheseldine / Son | 21269 Whites Neck Road, Bushwood, Maryland 20618 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | All Saints Cemetery | 4-24-2002 | Avenue, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Edward N. Brinsfield, Jr. M00052 | Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ~~Pneumonia~~ ASPIRATION PNEUMONIA | 1 Week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. ~~Aspiration~~ SWALLOWING DYSFUNCTION | ~~MONTHS~~ ~~Week~~ |
| | Due to (or as a consequence of): c. ~~Swallowing dysfunction~~ | ~~Months~~ |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D0055682 | 4/21/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas Wilkinson, M.D., Charlotte Hall, MD 20622

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| APR 23 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Medical Certification: To be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DOROTHY CHESELDINE ST MARY 234

19

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18539

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Barbara A. Dennis | May 15 2002 | 1825 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-66-0483 | 1☐M 2☒F | 46 Yrs. | | | Apr 23 1956 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Annapolis | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 250 A Apt. 202 Hill Top Lane | 21403 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10th | 0 | Homemaker | None |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| Benjamin A. Dennis | Rosa Crum |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Shavon Scott(Daughter) | 250 B Apt 106 Hill Top Lane Annapolis, Md. 21403 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Dennis Family Cemetery | 5/22/02 | Shady Side, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Harry B. Reese M00482 | Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive Heart Failure | 2 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Morbid Obesity

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Robert Scott Eden, MD | D30701 | 5/16/2002. |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert Scott Eden, 2002 Medical Pkwy, Annapolis, md. 21401

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 21 2002 | |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18540

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Philip Davidson

2. Date of Death Month 5 Day 15 Year 2002

3. Time of Death: 5:05 am

4e. Facility Name *(If not institution, give street and number)*: Genisis Eldercare The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 217-36-0475

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthdey)*: 102 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7-25-1899

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: QUEEN ANNE'S

10c. City, Town or Location: STEVENSVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 200 DAVIDSON FARM LANE

10f. Zip Code: 21666

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 YRS | College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FARMER

16b. Kind of Business/Industry: FARMING

17. Father's Name *(First, Middle, Last)*: PHILIP THOMAS DAVIDSON

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY MADLINE MITCHELL

19a. Informant's Name/Relationship *(Type, Print)*: LOUISE PRICE

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 200 PRICE FARM LANE STEVENSVILLE, MD 21666

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: OLD WYE PARISH

Date: 5/18/2002

20c. Location - City or Town, State: WYE MILLS, MD

21. Signature of Funeral Service Licensee: Chad M. [illegible]

22. Name and Address of Facility: FELLOWS, HELFENBEIN, & NEWNAM FUNERAL HOME P.A. 106 SHAMROCK RD CHESTER, MD 21619

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. Gangrene of both feet | >1 month |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Arteriosclerosis obliterans | >1 year |
| Due to (or as e consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: None

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert W. Trever, M.D

29c. License number: D0010938

29d. Date signed *(Month, Day, Year)*: May 15, 2002

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): ROBERT W. TREVER, M.D., 7696 OCEAN GATEWAY, EASTON, MD 21601

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAY 20 2002

32. Registrar's Signature: [illegible] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To be Completed by Funeral Director**

Philip Davidson
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item#8perFHG808 6/7/02 EW

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18541

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Matthew | | Davis | May | 13 | 2002 | 10:28 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| N/A | 1 [X] M 2 [ ] F | Yrs. | 1 | 13 | | | March 31, 2002 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | St. Mary's | Great Mills | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 45783 Nicholas Court | 20634 | U S A |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| N/A | | N/A | N/A |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Christopher David Sivak | Sharon Lynn Davis |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Christopher D. Sivak (Father) | 45783 Nicholas Court, Great Mills, Maryland 20634 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Brinsfield-Echols | May 17, 2002 | Charlotte Hall, Maryland |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| ▶ Mary Rizzo | M01114 | Brinsfield Funeral Home, P.A. P.O. box 279, Leonardtown, Maryland 20650 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. pseudomonas sepsis | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Pseudomonas pneumonia Due to (or as a consequence of): | 1 week |
| | c. chronic lung disease Due to (or as a consequence of): | 6 weeks |
| | d. prematurity | 6 weeks |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

anemia

thrombocytopenia

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [X] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ S Sherr MD | RES-000 | May 14 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SARAH SHERR 600 North Wolfe Street, Baltimore Maryland 21287-3200

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 21 2002 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ST MARY #8

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar: Amend Item#1 per Phy G808 6/7/02 EW

# State of Maryland / Department of Health and Mental Hygiene
## Certificate of Death

Reg. No. 2002 18542

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ~~LITO~~ ~~EVANGELISTA~~ Lito Evangelista
2. Date of Death (Month, Day, Year): May 08 2002
3. Time of Death: 6:10 AM
4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 152-44-2109
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 59 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 2, 1942
9. Birthplace (State or Foreign Country): Philippines

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1710 TIMBERLAKE DR.
10f. Zip Code: 21801
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: FILIPINO

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PHYSICIAN
16b. Kind of Business/Industry: INTERNAL MEDICINE

17. Father's Name (First, Middle, Last): JESUS M. EVANGELISTA
18. Mother's Name (First, Middle, Maiden Surname): PERPETUA MABALATAN

19a. Informant's Name/Relationship (Type, Print): LUCY Y. EVANGELISTA, MD - WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1710 TIMBERLAKE DR. SALISBURY, MD 21801

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WICOMICO MEM. PARK
Date: 5/11/2002
20c. Location - City or Town, State: SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee: ▶ B. Keat Pynn, CFSP
22. Name and Address of Facility: BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Fungal Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Febrile Neutropenia
Due to (or as a consequence of):
c. Marginal / B-cell lymphoma
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ■ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ■ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ■ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ■ No
26. Place of Death (Check only one): Hospital: 1 ■ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ■ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ■ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Roberto Scaffidi, MD
29c. License number: P13408
29d. Date signed (Month, Day, Year): May 8, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roberto Scaffidi, MD 22 South Green Street Baltimore, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAY 10 2002
32. Registrar's Signature: ▶ Denise G Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural', or Items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at 2029.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 | 8543

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Isabel M. Foltz | May 23, 2002 | 10:50 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 14018 Peddicord Rd. | Mt. Airy | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 206-12-7599 | 1☐M 2☒F | 80 Yrs. | | | Feb. 9, 1922 | Pennsylvania |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Mount Airy | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 14018 Peddicord Road | 21771 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Abner Ralph Koppenhaver | Helen Ossman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard G. Foltz - Husband | 14018 Peddicord Road, Mount Airy, Maryland 21771 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Parklawn Memorial Park | 5/28/2002 | Rockville, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Robert L. Williams | Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiac arrest | 4 minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Congestive heart failure | 9 years |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

NIDDM, Mitral Valve replacement, hypercholesterolemia

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☒Yes 2☐No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D46096 | May 23, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hope McIntyre, M.D. 1502 S. Main St., Mt. Airy, Md. 21771

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ Donna B Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural', or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18544

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Phyllis Flook | May 27 2002 | 6:15 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Northampton Manor Nursing Home | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-28-1214 | 1☐M 2☒F | 69 Yrs. | | | Dec. 31, 1932 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7929 Edgewood Farm Road | 21702 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Howard David Myers | Naomi Catherine Bloyer |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Howard O. Flook, Jr./Husband | 7929 Edgewood Farm Road, Frederick, Maryland, 21702 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Smithsburg Crematory | May 28, 2002 | Smithsburg, Maryland |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| ▶ P. Ryan McMillion | MO1202 | 106 East Church Street Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Severe Bipolar Depression

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Alzheimer's Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Failure to Thrive

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D0054636 | May 28, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Syed W. Haque, MD, 700 Montclaire Avenue, Frederick, Maryland, 21701

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | ▶ Jenna B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18545

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BESSIE FOSTER
2. Date of Death: Month 5 Day 16 Year 02
3. Time of Death: 1010 AM
4a. Facility Name (If not institution, give street and number): Annapolis Nursing + Rehab
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 579-05-0241
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 23, 1913
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 951 Heather Way
10f. Zip Code: 21401
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): John Henry Heins
18. Mother's Name (First, Middle, Maiden Surname): Rosa Fanny (unknown)

19a. Informant's Name/Relationship (Type, Print): Charles D. Wimpee, Jr./ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 951 Heather Way Annapolis, MD 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington Nat'l. Cemetery
Date: 6-11-02
20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. GANGRENE LEFT LEG
Due to (or as a consequence of):
b. PERIPHERAL VASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D23450
29d. Date signed (Month, Day, Year): May 16, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WALTER HEBNER 300 EAST JOPPA RD. SUITE 608 TOWSON, MD 21286

**State Registrar**

31. Date filed (Month, Day, Year): MAY 17 2002
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18546

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Edward | Gant | MAY 16 2002 | 10:27 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| College View Nursing Home | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-24-6015 | 1☑M 2☐F | 75 Yrs. | | | SEPT. 14, 1926 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | FREDERICK | FREDERICK | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1334 TANEY AVE. -APT-202 | 21702 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☑Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6th | | TRUCK DRIVER | HORN TRANSPORTATION |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| (UNK) | CATHERINE Gant |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CAROLINE GANT - WIFE | 800 MOTTER AVE FREDERICK MD. 21701 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | FAIRVIEW CEM | 5-22-02 | FREDERICK, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gary L. Rollins | GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST. FREDERICK MD 21701 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Prostate Cancer | Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and Title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Casper E. Cline III M.D. | MD016428 | 5/21/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CASPER E. CLINE III 300 West Ninth St Frederick, Maryland 21701

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ Donna B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18547

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Ray Samuel Gunter | May 22 2002 | 2:30 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 910 East "E" Street | Brunswick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 226-32-7313 | 1☒M 2☐F | 72 Yrs. | | | May 17, 1930 | Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Frederick | Brunswick | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 910 East "E" Street | 21716 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: Korean | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Mechanic | Cement Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Luther Hillard Gunter, Sr. | Bessie Belle Camper |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary A. Gunter, Wife | 910 East "E" Street, Brunswick, MD 21716 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Fairview Cemetery | 05/25/2002 | Buchanan, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Barbara A. Williams, Owner | John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. A. Rhythmia

Due to (or as a consequence of):

c. C.A.D.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Michael R. Behre, M.D. | D16979 | 5/23/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Church & Franklin Sts. Middletown, Md. 21769

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ Jeanne B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

127

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **Amended #26 per MD FCHD, KS 5/28/02** **Certificate of Death** 10b, 19a per FH Reg. No. 2002 18548

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|
| BRUNO | GARUNKSTIS | MAY | 24, | 2002 | 5:58 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 5885 Moss Creek Dr. | Mount Airy | CARROLL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 072-26-8605 | 1 [X] M 2 [ ] F | 77 Yrs. | | | OCT 15, 1924 | LITHUANIA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| NEW YORK | ~~QUEENS~~ Queens | REGO PARK | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 64-49 WETHEROLE STREET | 11374 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 5+ | CIVIL ENGINEER | CUNSULTING FIRM |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JONAS GARUNKSTIS | MARIJA ZASIMOWSKA |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Kristina Kurapka ~~KRISTINA KURAKA~~ / DAUGHTER | 5885 MOSS CREEK DRIVE, MT. AIRY, MD 21771 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | ST. CHARLES CEMETERY | 05/28/2002 | FARMINGDALE, NEW YORK |

21. Signature of Funeral Service Licensee: Paul P. Mackey

22. Name and Address of Facility: STAUFFER FUNERAL HOMES, P.A. 8 E. RIDGEVILLE BLVD, MT. AIRY. MARYLAND 21771

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Colon Cancer | 7 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home ~~5 [ ] Residence~~ 6 [X] Other (Specify) **Daughter's Residence**

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | 038409 | May 24, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Sharffman / 10753 Falls Rd./ Baltimore, MD

**State Registrar**

31. Date filed (Month, Day, Year) MAY 28 2002

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#26, 20b, 7

20

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18549

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Leon Bernell Grant Jr. | May 27 2002 | 3:05a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Shady Grove Adventist Hospital | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 060-44-5216 | 1☒M 2☐F | 49 Yrs. | | | March25,1953 | New York |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Damascus | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10105 Lewis Drive | 20872 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Communications Engineer | U. S. Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| Leon Grant Sr. | Ruby C. Smith |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Kathleen Grant / Wife | 10150 Lewis Drive, Damascus, Maryland 20872 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metropolitan Crematorium Inc. | May 29,2002 | Alexandria, Virginia |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Todd O'Wynn | Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxic encephalopathy — 6 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. aspiration pneumonia — 6 days

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

S/P renal/pancreas transplant
insulin dependent diabetes mellitus
alcoholism

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) — Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| MD | D33443 | May27, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan R. Pollack, M.D. 809 Vicks Mill Rd. Rockville, Md 20851

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 31 2002 | Brenda D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18550

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): IONA MAE GROSSNICKLE

2. Date of Deeth: Month: May Dey: 29 Year: 2002

3. Time of Death: 11:00 Am

4e Fecility Neme (If not institution, give street and number): Fahrney-Keedy Home & Village

4b. City, Town, or Location of Death: Boonsboro

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 212-24-5170

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): April 2, 1920

9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Myersville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 13 Poplar Street

10f. Zip Code: 21773

10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Lest): Leslie H. Long, Sr.

18. Mother's Name (First, Middle, Maiden Sumame): Nellie Routzahn

19a. Informant's Name/Relationship (Type, Print): Kenneth G. Grossnickle/son

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 8847 Pete Wiles Road, Middletown, MD 21769

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Grossnickle Ch of Brethren

Date: 6/1/02

20c. Location - City or Town, State: Myersville, MD

21. Signature of Funeral Service Licensee: Patt L. Ricketts

22. Name and Address of Facility: 504 Main Street Ricketts Funeral Home Myersville, MD 21773

**To Be Completed by Funeral Director**

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Heelth end Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.**

**Baltimore, Maryland 21215-0036**

Iona Grossnickle

**Physician /Medical Examiner**

23a. Part1. Enter the diseses or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or hert failure. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | RENAL FAILURE | 4 W |
| Due to (or es a consequence of): b. | PNEUMONIA | 4 W |
| Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last — Due to (or as e consequence of): c. | OSTEOPROSIS | 15 Y |
| d. | DEMENTIA | 10 Y |

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Plece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Iona Grossnickle

**Division of Vital Records, P.O. Box 68760,**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Signature end title of certifier

29c. License number: D52323

29d. Date signed (Month, Dey, Yeer): 5/29/12

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Khalid M. Waseem, M.D.; 19414-C Leitersburg Pike, Hagerstown, MD 21742

**State Registrar**

31. Dete filed (Month, Day, Year): MAY 31 2002

32. Registrar's Signeture

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

2002 18551

Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Elizabeth Howell Glandon | May 25 2002 | 10:05P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 734 Whitehall Beach Rd. | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 091-22-2257 | 1☐M 2☒F | 75 Yrs. | | | Sept. 19, 1926 | New York |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Annapolis | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 734 Whitehall Beach Rd. | 21401 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 1 | Homemaker | Own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jack Howell | Mary Hughes |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John J. Glandon / husband | 734 Whitehall Beach Rd. Annapolis, Md. 21401 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Baltimore Crematory | 5-28-2002 | Baltimore, Md. |

21. Signature of Funeral Service Licensee ▶ C Brian Powell

22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — Due to (or as a consequence of): — 1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Astrocytoma
Colon Resection

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature]

29c. License number DM35494

29d. Date signed (Month, Day, Year) 5/28/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Resnick MD 600 Ridgely Ave Suite 121 Annapolis

**State Registrar**

31. Date filed (Month, Day, Year) MAY 28 2002

32. Registrar's Signature ▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18552

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Barbara Ann Grashl | May 26, 2002 | 9:55 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-38-5805 | 1☐ M 2☒ F | 82 Yrs. | | | Nov. 21, 1919 | Germany |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Annapolis | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2737 Yeomans Lantern Court | 21401 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Homemaker | Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frederick Judith | Margaret Volz |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Rainer H. Joutz/ Nephew | 90 Wessex Way San Carlos, CA 94070 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Glen Haven Cemetery | 5-30-02 | Glen Burnie, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CHRONIC MYELOGENOUS LEUKEMIA — 8 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | DO8118 | MAY 27, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STANLEY WATKINS 500 RESEARCH RD ANNAPOLIS MD 21401

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18553

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: William Gniecko

2. Date of Death — Month: June; Day: 1; Year: 2002

3. Time of Death: 5:35 PM

4a. Facility Name *(If not institution, give street and number)*: William Hill Manor Health Care Center

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 218-14-2574

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: September 5, 1914

9. Birthplace *(State or Foreign Country)*: Rhode Island

Usual Residance of Decedent

10a. Stete: Maryland

10b. County: Caroline

10c. City, Town or Location: Denton

10d. Insida City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 300 Carter Avenue

10f. Zip Code: 21629

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Navar Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Give Year or Dates: 1941-1946

13. Was Dacadant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* Caucasian

15. Decedent's Education *(Specify only highest grade complatad)*: Elamantary/Secondary (0-12): 11 HS Grad. / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Self Employed Building Contractor

16b. Kind of Business/Industry: Construction

17. Fathar's Nama *(First, Middla, Last)*: Wasel Gniecko

18. Mothar's Name *(First, Middle, Maiden Sumama)*: Catherine Ponda

19a. Informant's Name/Relationship *(Type, Print)*: Mary Emily Gniecko Wife

19b. Mailing Address *(Straat and Numbar or Rural Route Number, City or Town, Stata, Zip Coda)*: 300 Carter Avenue, Denton, Maryland 21629

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Denton Cemetery

Date: 6/5/02

20c. Location - City or Town, Stata: Denton, Maryland

21. Signature of Funaral Sarvice Licensae: Randolph P. Moore

22. Name and Addrass of Facility: Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

**Physician /Medical Examiner**

23a. Part1. Entar the disaasa, or complications that causad the daath. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach line.

Approximate Intarval Between Onsat and Daath

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular arrythmia — 0

Due to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiate causa. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last

b. Electrolyte abnormality — 5D

Due to (or as a consequance of):

c. Acute Renal Failure — 8D

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause givan in Part I.

End stage renal disease

Diabetes

23b. Did tobacco use contribute to tha causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Rasidance 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding invastigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, date and place, and due to tha cause(s) and manner as stated. 2 [ ] **Medical Examinar:** On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, date and piece, end dua to tha cause(s) and mannar statad.

29b. Signatura and tita of certifier: [signature] MD

29c. Licansa number: D35284

29d. Data signad *(Month, Day, Year)*: 6/2/02

30. Name and addrass of parson who completed cause of death (Itam 23e) (Type, Print): ANDREA ACTON MD 420 Colonial Drive Denton MD 21629

**State Registrar**

31. Data filad *(Month, Day, Year)*: JUN - 3 2002

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar: Amend Item#13 per FHG808 6/7/02 EW

Reg. No. 2002 18554

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| CAROL KATHLEEN GALBUS | MAY 13, 2002 | 12:55 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 308 Brookview Drive | Salisbury | Wicomico |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 398-32-8047 | 1☐M 2☒F | 66 Yrs. | | | November 19,1935 | Wisconsin |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Salisbury | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 308 Brookview Drive | 21804 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | Nurse | Health Care |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Simon Hilger | Mary Walsh |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Kenneth J. Galbus/Husband | 308 Brookview Dr., Salisbury, MD 21804 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Salisbury Crematory | 5/16/02 | Salisbury, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Kelly K Rainey CFSP | Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC OVARIAN CARCINOMA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes ☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home ☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Catherine R Horner | D45005 | 5/16/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Catherine R. Horner 1104 Healthway Dr., Salisbury, MD 21804

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 20 2002 | ▶ Lenora G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

W.C. 13

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#23a per PHYG808 6/7/02 EW **Certificate of Death**

Reg. No. 2002 18555

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Retha Mae Groves

2. Date of Death: Month April Day 5 Year 2002

3. Time of Death: 8:20 PM M

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital Center

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 245-20-2359

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): 07/04/1922

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Oxon Hill

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 6906 Leyte Drive

10f. Zip Code: 20745

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: In Home

17. Father's Name (First, Middle, Last): Robert T. Wheeler

18. Mother's Name (First, Middle, Maiden Surname): Unknown Joyner

19a. Informant's Name/Relationship (Type, Print): Richard C. Groves / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6906 Leyte Drive Oxon Hill, Maryland 20745

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 04/07/2002

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: George P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEVERE PERIPHERAL VASCULAR DISEASE left leg - gangrene — Unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. HYPERTENSION — UNKNOWN

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☑ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rointan Farahifar M.D.

29c. License number: D43446

29d. Date signed (Month, Day, Year): 4/6/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROINTAN FARAHIFAR M.D 9801 Georgia Ave suit 3-35 SILVER SPRING MD 20902

**State Registrar**

31. Date filed (Month, Day, Year): APR 09 2002

32. Registrar's Signature: Jeanne B. Sparks

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other then 'natural', or Items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

GROVES, Retha expired @ 8080 Sr. Magdali 4-5-02 23a P.G.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended#8,10b,19a perFH FCHD

# Certificate of Death

Reg. No. 2002 18556

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|---|
| Daniel | Wilson | Harris | Sr | May 18, 2002 | 11:30am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 9549 Keys Chapel Road | Union Bridge | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-32-5539 | 1☒M 2☐F | 65 Yrs. | | | ~~JULY *8, 1936~~ July 8, 1936 | MD. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Frederick | UNION BRIDGE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9549 KEYS CHAPEL RD. | 21709 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | TRUCK DRIVER | FREDERICK CITY GOVERNMENT |
| 8TH | | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CARL HARRIS | LOUISE AMBUSH |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| GAIL HEBRON ~~(LADY)~~ (Daughter) | 1146 PROVIDENCE COURT FRED. MD 21703 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | ROSEHAVEN MEM. GARDEN | 5-23-02 | FRED. MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gary L. Rollins | Gary L. Rollins Funeral Home 110 West South St Frederick Md 21701 |

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): Arteriosclerotic Cardiovascular Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D35164 | May 23, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended#19b perFH FCHD,KS

# Certificate of Death

Reg. No. 2002 18557

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Rose Ellen Hilliard
2. Date of Death (Month, Day, Year): May 26, 2002
3. Time of Death: 11:10 PM
4a. Facility Name (If not institution, give street and number): Citizens Nursing Home
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 212-36-8298
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 27, 1902
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1900 Rosemont Ave.
10f. Zip Code: 21702
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self
16b. Kind of Business/Industry: homemaker

17. Father's Name (First, Middle, Last): Henry Hammerbacher
18. Mother's Name (First, Middle, Maiden Surname): Mary Reagan

19a. Informant's Name/Relationship (Type, Print): Mary Martin, niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6937 Meadowlake Rd., New Market, MD 21774 ~~Mt. Airy, MD 21771~~

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory | Date: 5/28/2002
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Ryan M Berger M00999
22. Name and Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — Approximate Interval Between Onset and Death: 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery (Month, Day, Year)

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D30456
29d. Date signed (Month, Day, Year): May 28, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Francis E. Becker, MD 300 W. 9th Street, Frederick, MD 21701

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18558

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Esther Mae Hurley | May 29, 2002 | 6:35A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Citizens Nursing Home | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-24-2980 | 1☐ M 2☒ F | 92 Yrs. | | | October 12, 1909 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 100 Burgess Hill Way - #209 | 21702 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Laboratory Technician | U.S. Government N.I.H. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Elmer Thompson | Vedah Beall |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sandra L. Watkins - Daughter | 11091 Sanandrew Drive, New Market, Maryland 21774 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Bethesda Meth. Cemetery | June 1, 2002 | Damascus, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Robert L. Williams | Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Hypertensive Cardio Vascular Disease | 5 yrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Robert L. Kaufmann | D-13971 | 5/29/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert L. Kaufmann, M.D. 300 West 9th Street, Frederick, Maryland 21701

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 31 2002 | ▶ Barbara G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar AMEND#20b 5/29/02 AACO HEALTH DEPT CMH

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18559

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Albert H. Higgins

2. Date of Death (Month, Day, Year): May 15, 2002

3. Time of Death: 1:45 A M

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 521-26-9613

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 9, 1919

9. Birthplace (State or Foreign Country): Colorado

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: X 1☐ Yes 2☐ No

10e. Street and Number: 837 Woodmont Road

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

**To Be Completed by Funeral Director**

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1944-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 1 year

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Equipment Specialist

16b. Kind of Business/Industry: US Department of Agriculture

17. Father's Name (First, Middle, Last): Albert R. Hahnewald

18. Mother's Name (First, Middle, Maiden Surname): Inga M. Herold

19a. Informant's Name/Relationship (Type, Print): Jean Higgins/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 837 Woodmont Rd. Annapolis, MD 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 5-16-02 ~~6-16-02~~

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Rupture

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MYOcardial Infarction

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Stroke

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D0053064

29d. Date signed (Month, Day, Year): 5-15-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Roschyn MD, Anne Arundel Med Ctr, Annapolis MD

**State Registrar**

31. Date filed (Month, Day, Year): MAY 17 2002

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18560

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Rose M. Hipps | May 23, 2002 | 5:20 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| FutureCare Chesapeake | Arnold | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-34-1340 | 1☐ M 2☒ F | 87 Yrs. | | | June 5, 1914 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Arnold | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 305 College Parkway | 21012 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Office Worker | Grocery Store |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph Helgert | Margaret Guntner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joan McManus/Daughter | 507 Likeston Court, Severna Park, MD 21146 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Oaklawn Cemetery | May 25, 2002 | Baltimore, MD |

21. Signature of Funeral Service Licensee: James E. Barranco

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home, 495 Gov. Ritchie Hwy, Severna Park, MD 21146

**Physician /Medical Examiner**

23a. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | 1 Day |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Coronary Artery Disease | 1 Year |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Type II Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| C.V. Cyriac MD Attending Doctor | D21684 | 5-23-02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C.V. CYRIAC M.D 8021 RITCHIE HWY, PASADENA, MD 21122

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 24 2002 | Penny P Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18561

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Llewellyn Theodore Jones | May 22 2002 | 3:30 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Millenium Health Care | Edgewater | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-05-1472 | XX 1 M 2 F | 86 Yrs. | | | Jan. 13, 1916 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Anne Arundel | Edgewater | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1418 Oak Bluff Road | 21037 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 X Yes 2 No If Yes, Give Year or Dates 1941-67 | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondery (0-12) | College (1-4or 5+) | | |
| 12 | | Military | U.S. Navy |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Savage Jones | Stella Marie Peddicord |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Frances H. Jones / Wife | 1418 Oak Bluff Road Edgewater, Md. 21037 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | St. Mary's Cemetery | 5-25-2002 | Annapolis, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Brian Powell | John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Stroke

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atrial fibrillation

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 X No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 Yes 2 X No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Scott M. MD | D34145 | 5/24/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott M. Rifkin, M.D. 21 Crossroads Dr. Owings Mills, Md 21117

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | |

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural', or items 28e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

# VOID

certificate no.
2002-18562

SEE

certificate no.
XXXXXX

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

Amend Item#24per Verbal 8086/7/02 EW

1- For State Registrar **Amened item #4 6/4/02 wchd/ew**

# State of Maryland / Department of Health and Mental Hygiene
# Certificate of Death

Reg. No. 2002 18563

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| ERNEST JAMES JONES | MAY 19 2002 | 5:30 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 34722 OLD OCEAN CITY RD. | PITTSVILLE | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| ~~212-40-7874~~ 222-40-7874 | 1☒ M 2☐ F | 60 Yrs. | | | 04/24/1942 | DELAWARE |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | WICOMICO | PITTSVILLE | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 34722 OLD OCEAN CITY RD. | 21850 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | TRUCK DRIVER | TRUCKING COMPANY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| ERNEST P. JONES | CLEORA MAUDE WOTTEN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| LUCILLE M. JONES - WIFE | 34722 OLD OCEAN CITY RD. PITTSVILLE, MD 21850 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | PITTSVILLE CEMETERY | 5/21/2002 | PITTSVILLE, MARYLAND |

21. Signature of Funeral Service Licensee: B Kent P Lynn CFSP

22. Name and Address of Facility: BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. 21804 SALISBURY, MD

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Lung Cancer | 8 mos |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D26278 | 5-20-02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID COHEN MD 145 E. Carroll St. Salisbury, MD 21801

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 20 2002 | G Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

N.C. 2/A

5 MP

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#23a perPHYG808 6/7/02 EW

# Certificate of Death

Reg. No. 2002 18564

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| HILDA MAE JEWELL | APRIL 26, 2002 | 6:30 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 208 PERRY'S CORNER ROAD | GRASONVILLE | QUEEN ANNE'S |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-20-0416 | 1☐ M 2☒ F | 87 Yrs. | | | FEB. 20, 1915 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | QUEEN ANNE'S | GRASONVILLE | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 208 PERRY'S CORNER ROAD | 21638 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | -0- | OWNER/OPERATOR | GAS STATIONS |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOSEPH PARKS | MYRTUS LANDON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| FRANKLIN JEWELL / SON | 104 STEAMBOAT AVE., QUEENSTOWN, MD 21658 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | WOODLAWN MEMORIAL PARK | 4-30-2002 | EASTON, MD |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. COPD | Several years Remote |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| Due to (or as a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hip fracture

**23b. Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] MD | D0005754 | 4-26-02 |

30. Name and address of person who completad cause of death (Item 23a) (Type, Print): DR. RALPH LIBBY, 205 MEDICAL CENTER ROAD, GRASONVILLE, MD 21638

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| APR 29 2002 | [signature] |

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P.A. 23a

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18565

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JAMES STEPHEN KENNEDY | MAY 29 2002 | 6:25 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 6001 MUNCASTER MILL ROAD | ROCKVILLE | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 240-66-6486 | 1☑M 2☐F | 59 Yrs. | | | MAY 27 1943 | NC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | MONTGOMERY | BOYDS | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 20504 TOP RIDGE DR. | 20841 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | PHARMACOLOGIST | DRUG |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOHN KENNEDY | LAURA HUMPHREYS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MYRA PROPST / SPOUSE | 20504 TOP RIDGE DR., BOYDS, MD 20841 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | FREDERICK CREMATORY | 6/1/02 | FREDERICK, MD |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, MD 20838

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LARYNGEAL CARCINOMA — MONTHS

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death bul not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☑Other (Specify) HOSPICE

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D42452 | MAY 30, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. CHITRA RAJAGOPAL 18111 PRINCE PHILLIP DR. #327 OLNEY, MD 20832

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 31 2002 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospitel or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

12

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18566

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Anna Kalinoski | May 12 2002 | 1:00 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 707 Maiden Choice Lane Apt. 3207 Charlestown Retirement Community | Catonsville | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 182-16-8542 | 1☐M 2☒F | 80 Yrs. | | | Jan. 11, 1922 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Catonsville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 707 Maiden Choice Lane Apt. # 3207 | 21228 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| (Unknown) Babkowski | (Unknown) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jerome M. Conser/Nephew | 26 Renault Drive Flanders, NJ 07836 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | MD Veterans Cemetery | May 16, 2002 | Crownsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ James E Barranco | Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Atherosclerotic heart disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Peter P Lamy MD | 047177 | May 14, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
7845 Oakwood Rd Suite 201 Glenburnie MD 21061, Peter Lamy MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 16 2002 | Donna B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18567

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Rhonda Leigh Kakrada | May 8, 2002 | 1715 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-54-9822 | 1☐M 2☑F | 52 Yrs. | | | December 30, 1949 | Washington, D.C. |

**Funeral Director**

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Annapolis | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2574 Riva Road Apt. 5A | 21401 | United States of America |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4 | Educator | AA. Co. Public Schools |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph Parker | Reba Matthews |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Stephen Kakrada-Husband | 1835 Drew St Annapolis, MD 21401 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Lakemont Memorial | May 17, 2002 | Davidsonville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | Miller's Metropolitan Chapel 1922 Forest Dr. Annapolis, MD |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | Cerebral edema | 48 hrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a consequence of): Arteriovenous malformation of the brain | years |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Sjoerd Beck, MD | D46052 | 5/8/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sjoerd Beck, MD 2002 Medical Parkway, Annapolis, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 17 2002 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18568

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Rose | Christine | Lewis | May | 23 | 2002 | 2:20 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Frederick Memorial Hospital | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 215-42-3874 | 1☐M 2☒F | 61 Yrs. | | | | | Aug 19 1940 | Brunswick, MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Frederick | Brunswick | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 207 East "G" Street | 21716 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Hostess | Stone Manor Jefferson, MD |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Michael A. Dallas | Lola E. Devine |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Cecelia McLane, Daughter | 609 West Potomac Street, Brunswick, MD 21716 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | St. Mary's Cemetery | 5/27/2002 | Petersville, MD |

| 21. Signature of Funeral Service License | 22. Name and Address of Facility |
|---|---|
| ▶ Barbara A. Williams, Owner | John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. intracerebral hemorrhage | 2hrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Dennis Winters | D0054619 | 5/24/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Winters, 141 Thomas Johnson Dr., Frederick, MD 21701

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ Brenda G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

110

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18569

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Walter Edward Loveless | May 13, 2002 | 5:00 A.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1618 Bentley Road | Edgewater | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-38-9569 | 1☒M 2☐F | 89 Yrs. | | | Oct. 28, 1912 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Anne Arundel | Edgewater | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1618 Bentley Rd. | 21037 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☐No If Yes, Give Year or Dates: '30-'58 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Military Officer | US Army |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Henry Loveless | Mabel Goddard |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Edna Loveless (wife) | 1618 Bentley Rd. Edgewater, MD. 21037 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Cremation Cntr. | 5-15-02 | Chester, MD. |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| ▶ D Adams | M00982 | Adams Funeral & Memorial Care 1000 Bestgate RD. Suite 201 Annapolis, MD. 21401 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____

Due to (or as a consequence of):

c. ____

Due to (or as a consequence of):

d. ____

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ____ 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure, Diabetes

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Theresa M Cuoco, MD | VA 0101840404 | May 13, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THERESA CUOCO 1050 West Perimeter Rd. Internal Medicine Andrews Air Force Base, Maryland

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 16 2002 | ▶ Denise B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18570

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Lena Tyler Meredith | May 27 2002 | 7:00 P.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 115 Vue de L'eau St. | Cambridge | Dorchester |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-34-3324 | 1☐M 2☒F | 91 Yrs. | | | Aug. 31, 1910 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Dorchester | Cambridge | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 115 Vue de L'eau St. | 21613 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | sales clerk | office supply |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Wilfred Tyler | Lucy Mae Lewis |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Willamae Sherman - daughter | 6214 Westbrooke Dr., Salisbury, MD 21801 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Dorchester Memorial Park | 5/31/02 | Cambridge, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Kenneth R. Thomas Jr | Thomas Funeral Home, P.A. 700 Locust St., Cambridge, MD 21613 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARREST — Approximate Interval Between Onset and Death: min

Due to (or as a consequence of):
b. Heart Failure — sdays

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Coronary Artery Disease — 3 years

Due to (or as a consequence of):
d. Arteriosclerosis — 15 years

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No |
|---|---|

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Robert M. McDonald, MD | D0009024 | 5/28/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert M McDonald, MD 30 Dover St. Easton, MD 21601

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | ▶ Jeanne S. Spates |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18571

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Charles Henry McPherson ,Jr.

2. Date of Death: Month May Day 29 Year 2002

3. Time of Death: 2:17AM

4e. Facility Name (If not institution, give street end number): 16900 St. Mary's Church Road

4b. City, Town, or Location of Death: Aquasco

4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 218-18-2217

6. Sex: 1 X M 2 F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 19,1922

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Aquasco

10d. Inside City Limits: 1 Yes 2 X No

10e. Street end Number: 16900 St. Mary's Church Road

10f. Zip Code: 20608

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 Never Married 2 XX Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Farmer

17. Father's Neme (First, Middle, Last): Charles Henry Adams McPherson, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Emily Ruth Summers

19a. Informant's Name/Reletionship (Type, Print): Mary Anne McPherson/Wife

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 16900 St. Mary's Church RD Aquasco, MD 20608

20a. Method of Disposition: XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St.Mary's Church Cemetery

Date: June 3,2002

20c. Location - City or Town, State: Bryantown, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Brinsfield-Echols Funl.Hme.,P.A. 30195 Three Notch RD Charlotte Hall, MD 20622

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

b. DILATED CARDIOMYOPATHY

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 Yes 2 X No

25. Wes case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA | Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Menner of Deeth: 1 X Naturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigetion 6 Could not be determined

28e. Date of Injury (Month, Dey Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: [signature] MD

29c. License number: D53885

29d. Date signed (Month, Day, Year): 5/29/02

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): VENKAT S. KAMAVARAM 6 POST OFFICE ROAD #101 WALDORF MD 20602

**State Registrar**

31. Dete filed (Month, Day, Year): MAY 30 2002

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Marital Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

expired 5-29-02 @ 2:17AM

Charles McPherson

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18572

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Edward Mullican, Sr.

2. Date of Death: Month May Day 22 Year 2002

3. Time of Death: 8:20 P M

4a. Facility Name (If not institution, give street and number): 1644 Andover Lane

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 578-48-3132

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct.11, 1939

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1644 Andover Lane

10f. Zip Code: 21702

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): Robert Brandon Mullican

18. Mother's Name (First, Middle, Maiden Surname): Helen Irene Stotler

19a. Informant's Name/Relationship (Type, Print): Robert E. Mullican, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1905 Ardlyn Court Bowie, Maryland 20716

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Frederick Crematory, Inc

Date: 5/29/02

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardio Vascular Disease — Years.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D35164

29d. Date signed (Month, Day, Year): May 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Zarick, Jr. MD 1080 W. Patrick St Frederick, MD 21703

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**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#26 perVerbalG808 6/7/02 EW

# Certificate of Death

Reg. No. 2002 18573

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| MARTHA | JEAN | MCDANIEL | MAY 8 2002 | 9:48 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Bethesda Naval Hospital | Bethesda | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 425 06 9609 | 1☐M 2☒F | 46 Yrs. | | | Jan 7, 1956 | Texas |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Mississippi | Harrison | Gulfport | 1☐Yes 2☐No X |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15340 Hamilton Street | 39503 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Caretaker | Humane Society |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Aubrey Oglesby | Ann Kerr |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20762 |
|---|---|
| Bobbie Prestridge (DAUGHTER) | 2075 A Tucson Ave, Andrews Airforce Base, MD |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) Date | 20c. Location - City or Town, State |
|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | May 15, 2002 Biloxi National Cemetery | Biloxi, Mississippi |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. GUNSHOT WOUND OF THE CHEST WITH PERFORATION OF AORTA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined | MAY 8 2002 | 9:48 P M | 1☐Yes 2☒No | GUNSHOT |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| BASE HOUSING | ANDREWS AIR FORCE BASE |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature], MD | 38593 (NC) | MAY 9 2002 |

| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | |
|---|---|
| JAMES L. CARUSO, CDR, MC, USN | ARMED FORCES INSTITUTE OF PATHOLOGY ROCKVILLE MD |

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 13 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P.G. 26

CR 12

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item#23a perPHYG808 6/7/02 EW

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18574

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Mary N. Myers | March 29, 2002 | 11:15 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 178-18-2640 | 1☐M 2☒F | 92 Yrs. | | | Dec. 11, 1909 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Annapolis | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 26 Murray Avenue | 21401 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Homemaker | Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph Parker Norris | Mary Rawlings Brady |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Katherine M. Calhoon/ Daughter | 243 Overleaf Drive Arnold, MD 21012 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Arlington Natl. Cemetery | 4-12-02 | Arlington, Virginia |

21. Signature of Funeral Service Licensee ▶ Robert P. Allen

22. Name and Address of Facility George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ~~ASPIRATION OF GASTRIC CONTENTS~~ ASPIRATION PNEUMONIA | ~~10 minutes~~ |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Small Bowel Obstruction | 1 week |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ ~~Titus Abraham~~, M.D. | D0056658 | MARCH 29, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TITUS ABRAHAM, M.D. HOSPITALIST DIVISION, ANNE ARUNDEL MEDICAL CENTER 2001 Medical Pkwy Annapolis, Md 21401

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| APR 02 2002 | ▶ Penny P Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a
A.A

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#20a perFHG808 6/7/02 EW

# Certificate of Death

Reg. No. 2002 18575

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| LISA RENEE MADISON | May 13, 2002 | 1:18 AM |

| 4a Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington Adventist Hospital | Takoma Park | Montgomery |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-78-8229 | 1☐ M 2☒ F | 46 Yrs. | | | April 11, 1956 | Washington, DC |

**Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| D.C. | N/A | Washington | 1☒ Yes 2☐ No |

| 10e. Street end Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 214 Whittier Street, N.W. | 20012 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Librarian | D.C. Public Schools |

| 17. Father's Name (First, Middle, Lest) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Hubert Madison | Margaret Carter |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Margaret Madison (mother) | 214 Whittier St. N.W., Washington, D.C. 20012 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Rock Creek Cemetery | 5/17/02 | Washington, D.C. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Thomas G. Clyburn | McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Wash. D.C. 20012 |

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**Physician Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Respiratory Arrest | |
| Due to (or as a consequence of): | b. Asthma | |
| Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Sleep Apnea | |
| Due to (or as a consequence of): | d. Cor pulmonale | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

obesity

hypertension

**23b. Did tobacco use contribute to the cause of deeth?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

| 29a. Certifier (Check only one) | |
|---|---|
| 1☒ | **Certifying Phyeicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
| 2☐ | **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. |

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D 54481 | May 14 2002 |

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

David H. Plotkin, M.D. 18111 Prince Philip Dr. Ste. 304, Olney, MD 20832

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 15 2002 | Geneva G. Sparks |

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18576

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): Mary Ellen Novak
2. Dete of Deeth — Month, Dey, Year: May 17, 2002
3. Time of Death: 12:50 a.m.
4a Fecility Neme (If not institution, give street end number): 3123 Stonehenge Dr.
4b. City, Town, or Location of Death: Riva
4c. County of Deeth: Anne Arundel

**Funeral Director**

5. Social Security Number: 281-36-7999
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): April 22, 1909
9. Birthplace (State or Foreign Country): Ohio

Usuel Residence of Decedent

10a. Stete: MD.
10b. County: Anne Arundel
10c. City, Town or Location: Riva
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3123 Stonehenge Dr.
10f. Zip Code: 21140
10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Samuel Daniska
18. Mother's Name (First, Middle, Maiden Surname): Suzanne Daniska

19a. Informant's Name/Relationship (Type, Print): Cynthia Rygiel (daughter)
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 3123 Stonehenge Dr. Riva, MD. 21140

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Chesapeake Cremation Cntr. — Date: 5-18-02
20c. Location - City or Town, State: Chester, MD.

21. Signature of Funeral Service Licensee: [signature] (M00982)
22. Name and Address of Facility: Adams Funeral & Memorial Care, 1000 Bestgate Rd. Annapolis, MD. 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Coronary Artery disease — X/S

Due to (or as a consequence of):
b. Dementia — Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HyperTension
Chronic Atrial Fibrillation

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No

26. Plece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Nature 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D41978
29d. Date signed (Month, Day, Year): 5-17-2002

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print): Nader Tavakoli 4000 Mitchellville Rd A312 Bowie MD. 20716

**State Registrar**

31. Date filed (Month, Day, Year): MAY 17 2002
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the death certificete be executed within 24 hours efter death.
**To the Funeral Director:** After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend Item#23a perPHYG808 6/7/02 EW Amend #5.Per Fam.PGC 5-10-02 cr

# Certificate of Death

Reg. No. 2002 18577

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month / Day / Year) | 3. Time of Death |
|---|---|---|
| Gertrude B. Narcisse | May 4 2002 | 8:27 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| ~~433-56-7090~~ 888-39-7287 | 1 ☐ M 2 ☒ F | 91 Yrs. | | | Sept. 6, 1910 | Louisiana |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George's | Bowie | 1 ☒ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15734 Ensleigh Lane | 20716 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | 4 | Registered Nurse | Nursing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jack Brandon | Ellen (UnAvailable) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ellen Adams Daughter | 15734 Ensleigh Lane Bowie Maryland 20716 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | The Huntt Crematory | May 7, 2002 | Waldorf Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael D. Bagley | Robert E. Evans Funeral Home 16000 Annapolis Rd. Bowie Maryland 20715 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. severe anemia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Gastrointestinal Bleeding | |
| | Due to (or as a consequence of): c. CEREBROVASCULAR ACCIDENT | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month / Day / Year) |
|---|---|---|
| 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

severe dementia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ N/A MD | D0051437 | 05/04/2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
OKEOWO DARCY IBITOYE AAMC 2001 MEDICAL PARKWAY ANNAPOLIS MD.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 08 2002 | Gerdine B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (4)

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18578

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| GRACE | | OAKSMITH | MAY 14 2002 | 6:18P M |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | |
| JOHNS HOPKINS BAYVIEW | BALTIMORE | | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-14-8345 | 1☐M 2☒F | 81 Yrs. | | | Feb. 20, 1921 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Annapolis | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1424 Catlyn Place | 21401 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Admunistrative Assistant | City Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| William Preston Harrison | Grace Myrtle Smith |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Barbara O. Smith / Daughter | 17 North Cherry Grove Ave. Annapolis, MD 21401 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Glen Haven Cemetery | 5/18/2002 | Glen Burnie, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael J. Sloan | John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Colonic Obstruction — Due to (or as a consequence of): — 1 Day

c. — Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ____ 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure
Neutropenia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Andrew Allen Pieper MD | 22022 | MAY 15, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANDREW ALLEN PIEPER MD 4940 EASTERN AVE. BALTIMORE, MARYLAND 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 17 2002 | ▶ [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18579

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month Day Year) | 3. Time of Death |
|---|---|---|
| John Gary Parks | May 27 2002 | 0844 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-28-2260 | 1☒M 2☐F | 71 Yrs. | | | July 20, 1930 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Dorchester | Cambridge | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5516 Mallard Lane | 21613 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1951-2 | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | diesel mechanic | engine repair |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Logan Benjamin Parks | Rosa Woodland |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gary Parks - son | P. O. Box 416, Mardela Springs, MD 21837 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Dorchester Memorial Park | 5/31/02 | Cambridge, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ John L. Thomas | Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT — 2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

PREVIOUS STROKE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] M.D. | D24168 | 5/27/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT ALLEN, M.D. 100 TOWER ST., SALISBURY, MD 21802

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | ▶ [signature] |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

215-28-2260 Ladd

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

John G. Parks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18580

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Queenie Mae Patterson
2. Date of Death (Month, Day, Year): May 29, 2002
3. Time of Death: 11:40 p.M
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 418-16-7952
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 9, 1921
9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: ☒Yes 2☐No
10e. Street and Number: 2609 Warren Way
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerical
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): William Isaac Riley
18. Mother's Name (First, Middle, Maiden Surname): Sarah Lord

19a. Informant's Name/Relationship (Type, Print): Janie Steplowski - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 602 Lion's Gate Lane, Odenton, Maryland 21113

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Frederick Crematory
Date: May 30, 2002
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Sharon Camille Caline
22. Name and Address of Facility: Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration Pneumonia — 5days
Due to (or as a consequence of):
b. Acute Renal Failure — 6 days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Left Hip Fracture — 8 days.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia, Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): May 21, 2002
28b. Time of Injury: 10:00 AM
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: Fell at Nursing home
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Nursing Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1900 Rosemont Ave Frederick, MD

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D35164
29d. Date signed (Month, Day, Year): May 30, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Zarick, Jr. MD 1080 W. Patrick St Frederick, MD 21703

3

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002
32. Registrar's Signature: James B Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2002 18581

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Virginia Dawson Laubach Pettebone | May 21 2002 | 10:58 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 512-12-0841 | 1☐M 2☒F | 87 Yrs. | | | May 14, 1915 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Anne Arundel | Annapolis | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3204 River Crescent Drive | 21401 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Admin. Assistant | U.S. Govt. Naval Academy |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Allen P. Dawson | Lola I. Ward |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Christine Alvey/Great niece | 102 Dreams Landing Way Annapolis, Md. 21401 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Baltimore Crematory | 5-22-2002 | Baltimore, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ C Brian Powell | John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. MYOCARDIAL INFARCTION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ John J Kennedy MD | D 44837 | MAY 05, 21, 2002 |

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)
JOHN J KENNEDY SUITE 500 SAJAK PAVILION 21401 ANNAPOLIS, MARYLAND

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 23 2002 | Denise P Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural', or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18582

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Marian Frances Prattis

2. Date of Death (Month, Day, Year): May 24 2002

3. Time of Death: 12:07 PM

4a. Facility Name *(If not institution, give street and number)*: Genesis ElderCare - The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 213-16-8619

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 03/22/19

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Talbot

10c. City, Town or Location: Easton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 610 Dutchman's Lane

10f. Zip Code: 21601

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles Tingle

18. Mother's Name *(First, Middle, Maiden Surname)*: Gertie Lee Prattis

19a. Informant's Name/Relationship *(Type, Print)*: Janice Prattis/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 406 Muir St. Apt. 2, Cambridge, Maryland

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Federal Hill Cem. Date: 5/31/02

20c. Location - City or Town, State: Federalsburg, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Frampton-Hawkins-Eskow Funeral Home, PA Box 43, Federalsburg, MD 21632

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Renal failure — weeks

Due to (or as a consequence of):
b. End-stage renal disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Atherosclerosis — years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D25933

29d. Date signed *(Month, Day, Year)*: 5-24-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL CROWLEY, MD 508 IDLEWILD AVENUE EASTON, MD 21601

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 28 2002

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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Marian Prattis
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Amend Item#23a, perPHYG808 6/7/02 EW

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar AMEND#1,5 Per Phy. 4/30/02 cmh Health Dept

# State of Maryland / Department of Health and Mental Hygiene
## Certificate of Death

Reg. No. 2002 18583

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thelma ~~Thelam~~ Lydia Pritchard

2. Date of Death: Month April Day 14, Year 2002

3. Time of Death: 12:15 a M

4a. Facility Name (If not institution, give street and number): 224 St. Ives Drive

4b. City, Town, or Location of Death: Severna Park

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: ~~557-16-5755~~ ~~551-12-3615~~

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 24, 1922

9. Birthplace (State or Foreign Country): CA

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 224 St. Ives Drive

10f. Zip Code: 21146

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Ernst C. Amling

18. Mother's Name (First, Middle, Maiden Surname): Lydia Hinz

19a. Informant's Name/Relationship (Type, Print): JoAnne Mitchell/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 224 St. Ives Drive, Severna Park, MD 21146

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: Apr. 17, 2002

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: James E. Barranco

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. multi system Atrophy — 1½ years

Due to (or as a consequence of):
b. ASPIRATION PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen Reich MD

29c. License number: D3 7272

29d. Date signed (Month, Day, Year): April 16, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Reich, MD Johns Hopkins Outpatient Center 5501 Baltimore, MD 21287

**State Registrar**

31. Date filed (Month, Day, Year): APR 17 2002

32. Registrar's Signature

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P.O. Box 68760

DHMH 17 Rev 1/2001

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND #23 PART II PER PHY 5/30/02 CCHD DB *Certificate of Death* Reg. No. 2002 18584

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| SENGSOURICHANH RATANAVONG | | MAY 27, 2002 | 2:10 P.M |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | |
| 17314 B CROOM ROAD | BRANDYWINE | PRINCE GEORGE'S | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-92-1127 | 1☐M 2☒F | 48 Yrs. | | | APRIL 16, 1954 | LAOS |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | PRINCE GEORGE'S | BRANDYWINE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 17314 B CROOM ROAD | 20613 | LAOS |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: ASIAN |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | CASHIER | RETAIL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| INPENG THAMMAVONGSA | SISOUDA PHONESAVANH |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| PHOUSAYSONGKHAM RATANAVONG-HUSBAND | 17314 B CROOM RD., BRANDYWINE, MARYLAND 20613 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) THE | HUNTT CREMATORY | 6/02/2002 | WALDORF, MARYLAND |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| JPK ▶ JOHN P. KNISLEY | MO1164 | THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Interstitial lung disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SCLERODERMA OVERLAP SYNDROME

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month / Day / Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

~~SCLERODERMA OVERLAP SYNDROME~~

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Hawani Temesgen M.D | D46576 | 5/28/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAWANI TEMESGEN, 6104 OLD BRANCH AVENUE, TEMPLE HILLS MD 20748

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | Jessie G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18585

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GUY ROELKEY RAMSBURG, JR.

2. Date of Death: Month MAY Day 22, Year 2002

3. Time of Death: 5:45 PM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 219-12-0689

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 13, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10123 A Old Liberty Road

10f. Zip Code: 21701

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self

16b. Kind of Business/Industry: amusements

17. Father's Name (First, Middle, Last): Guy Roelkey Ramsburg, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ethel Summers

19a. Informant's Name/Relationship (Type, Print): M. Ethel Young Ramsburg, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10123 A Old Liberty Road, Frederick, MD 21701

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: 5/28/2002

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Berger MO0999

22. Name and Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. STROKE — 3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. METASTATIC ADENOCARCINOMA — Unknown

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D41378

29d. Date signed (Month, Day, Year): 5/24/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Costello, MD, 730 Old Liberty Road, Eldersburg, MD 21784

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature: Pamela P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **Amended#2perMD FCHD,KS 5/30/02** **Certificate of Death** Reg. No. 2002 18586

Physician /Medical Examiner

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Frances | Carolyn | Redmond | ~~May 24,~~ May 23, 2002 ~~2002~~ | 6:30A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Frederick Memorial Hospital | Frederick | Frederick |

Funeral Director

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 228-58-8888 | 1☐M 2☒F | 59 Yrs. | | | Nov. 6, 1942 | VA. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Frederick | Brunswick | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 215 13th Ave. | 21776 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | homemaker | own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Maurice F. Beazley | Bessie L. Carlton |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John Redmond (Husband) | 215 13th Ave., Brunswick, MD. 21776 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Harmony Cemetery | 5/26/02 | Myersville, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769 |

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. myocardial infaraction | 1 hour |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): pneumonia | weeks |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

empyema, renal failure

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☑Yes 2☐No 3☐Probably 4☐Unknown | 1☑Yes 2☐No | 1☐Yes 2☑No |

Medical Certification: To Be Completed by Physician/Medical Examiner

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

| 29a. Certifier (Check only one) | |
|---|---|
| 1☑ | **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
| 2☐ | **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D47169 | 5-24-2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HO, Chan-hing 610 9th AVE, BRUNSWICK, MD 21716

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | ▶ [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18587

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| WALTER ELMER ROBINSON | MAY 21 2002 | 6:59 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| NATIONAL NAVAL MEDICAL CENTER | BETHESDA | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 483-48-3258 | 1[X] M 2[ ] F | 90 Yrs. | | | March 28, 1912 | Iowa |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Anne Arundel | Annapolis | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8 Cypress Road | 21403 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[ ] Never Married 2[ ] Married 3[X] Widowed 4[ ] Divorced | 1[X] Yes 2[ ] No If Yes, Give Year or Dates: 1932-62 | 1[ ] Yes 2[X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Chief Communication Tech. | U.S. Navy |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Walter M. Robinson | Christina Juhl |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Melda L. Hone / daughter | 8 Cypress Rd. Annapolis, Md. 21403 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[ ] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[X] Other (Specify) Entomb. | Hillcrest Mem. Gard. | 5-25-2002 | Annapolis, Md. |

21. Signature of Funeral Service Licensee ▶ Brian Powell

22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. INTERSTIAL LUNG DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1[ ] Yes 2[ ] No 9[ ] Unknown | 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1[ ] Yes 2[X] No | 1[ ] Yes 2[ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1[ ] Yes 2[X] No | Hospital: 1[X] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | | M | 1[ ] Yes 2[ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1[X] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2[ ] **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M.D. | 9900246 (NC) | 5/21/2002 |

| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | |
|---|---|
| ERIC D. HIGH, LT, MC, USNR | NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 |

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 24 2002 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#26 #1 perPHYG808 6/10/02EW **Certificate of Death** Reg. No. 2002 18588

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ~~Sidney Rubin~~ Sidney Rubin

2. Date of Death: Month MAY Day 23 Year 2002

3. Time of Death: 1206 PM

4a. Facility Name (If not institution, give street and number): UMMS Shock Trauma Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 579-22-7699

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): AUG. 3, 1926

9. Birthplace (State of Foreign Country): CONNECTICUT

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 621 HAWKESBURY TERRACE

10f. Zip Code: 20904

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-47

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ___ College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ACCOUNTANT

16b. Kind of Business/Industry: ACCOUNTING

17. Father's Name (First, Middle, Last): NATHAN RUBIN

18. Mother's Name (First, Middle, Maiden Surname): MARY BENJAMIN

19a. Informant's Name/Relationship (Type, Print): PEGGY B. RUBIN-WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 621 HAWKESBURY TERR SILVER SPRING, MD 20904

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): KING DAVID MEM GARD.

Date: 5/26/2002

20c. Location - City or Town, State: FALLS CHURCH, VA

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE ROCKVILLE, MD 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Traumatic Brain injury — 20h

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. [illegible]

Due to (or as a consequence of):

c. [illegible]

Due to (or as a consequence of):

d. [illegible]

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ___ 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient TRU 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): 05 22 02

28b. Time of Injury: 1530 M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: Fall

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 621 Hawkesbury Terrace SS, MD 2090[illegible]

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: AN 176435-10465

29d. Date signed (Month, Day, Year): 05 23 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES FOX, MD. UMMS. Shock Trauma, Baltimore, MD. 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18589

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ERNEST SCHWANSTROM

2. Date of Death Month / Dey / Year: May 29, 2002

3. Time of Death: 8:14pm

4e. Facility Name *(If not institution, give street end number)*: Civista Medical Center

4b. City, Town, or Location of Death: LaPlata

4c. County of Death: Charles

**Funeral Director**

5. Social Security Number: 050-26-7724

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APRIL 18, 1928

9. Birthplace *(State or Foreign Country)*: ILLNOIS

Usuel Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: LA PLATA

10d. Inside City Limits: 1☒ Yes 2☐ No — X

10e. Street end Number: 1 MAGNOLIA DRIVE

10f. Zip Code: 20646

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married — X — 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☒ Yes 2☐ No — X — If Yes, Give Yeer or Dates: ARMY 1949-52

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No — X — *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Eduetion *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: CONSTRUCTION WORKER

16b. Kind of Business/Industry: CONSTRUCTION

17. Fether's Neme *(First, Middle, Last)*: ERNEST V. SCHWANSTROM

18. Mother's Name *(First, Middle, Maiden Surneme)*: unknown MILLS

19a. Informant's Name/Relationship *(Type, Print)*: WANDA STURMAN-GUARDIAN

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 1 MAGNOLIA DRIVE LA PLATA,MD. 20646

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State — X — 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: METROPOLIAN CREMATORY

Date: 5-30-02

20c. Location - City or Town, State: ALEXANDRIA,VA.

21. Signature of Funeral Service Licensee: MO0479 — Michael O. [illegible]

22. Name and Address of Facility: RAYMOND FUNERAL SERVICE,P.A. LA PLATA,MARYLAND 20646

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Intracerebral Hemorrhage

Due to (or es a consequence of): Hypertension

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last

b. [illegible]

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of *my* knowledge, deeth occurred at the time, date end piece, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier

29c. License number: D-45737

29d. Date signed *(Month, Day, Year)*: 5/30/02

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Gurusamy, Nirmaladevi, MD, 3328 Old Washington Rd., Waldorf, MD 20602

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 30 2002

32. Registrer's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health end Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Schwanstrom, Ernest H.
**Baltimore, Maryland 21215-0020**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours efter death.

**To the Funeral Director:** After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18590

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Anna Margaret Schroeder

2. Date of Death (Month, Day, Year): May 23, 2002

3. Time of Death: 5:15 PM

4a. Facility Name (If not institution, give street and number): Homewood at Crumland Farms

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 218-30-8659

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 29, 1914

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7407 Willow Road

10f. Zip Code: 21702

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Albert Franklin Culler

18. Mother's Name (First, Middle, Maiden Surname): Kathryn Rebecca Null

19a. Informant's Name/Relationship (Type, Print): Mrs. Kathryn Shue, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 St. Bernard Dr., Vienna, Virginia 22180-3661

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery, May 31, 2002

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Richard E. Gray M00255

22. Name and Address of Facility: Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — 1 wk

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Alzheimer's Disease — 10 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery (Month, Day, Year)

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Austin Pearre Jr

29c. License number: D09689

29d. Date signed (Month, Day, Year): May 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Austin Pearre, Jr., M.D., 300 West Ninth Street, Frederick, Md. 21701

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: Geneva G Sparks

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18591

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ruth Elaine Smith
2. Date of Death (Month, Day, Year): May 27, 2002
3. Time of Death: 11:40 AM
4a. Facility Name *(If not institution, give street and number)*: St. Catherine's Nursing Home
4b. City, Town, or Location of Death: Emmitsburg
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 216-30-2945
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yeer)*: Feb. 12,1934
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Emmitsburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 331 South Seton Avenue
10f. Zip Code: 21727
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manufacturer
16b. Kind of Business/Industry: Optical Equipment

17. Father's Name *(First, Middle, Last)*: John S. Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth E. Bowers

19a. Informant's Name/Relationship *(Type, Print)*: Christine Smith / Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18 Mile Trail; Fairfield, PA 17320

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resthaven Crematory
Date: 5/28/02
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Ischemic Cardiomyopathy | 2 mo |
| Due to (or as a consequence of): b. | Atherosclerotic Heart Disease | >10 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Hypertension | >20 yrs. |
| Due to (or as a consequence of): d. | | |

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Insulin Dependent Diabetes Mellitus; Multiple Cerebral Infarctions

23b. Did tobacco use contribute to the ceuse of deeth? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Exeminer**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Alan Carroll MD
29c. License number: D18705
29d. Date signed *(Month, Day, Yeer)*: 5/27/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan L. Carroll, M.D. 310 Seton Ave. Emmitsburg, MD 21727

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 31 2002
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18592

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Louis Edward Smith | May 29, 2002 | 2:34 AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington Adventist Hospital | Takoma Park | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-18-1913 | 1 ☐ M 2 ☐ F X | 78 Yrs. | | | July 19, 1923 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1 ☐ Yes 2 ☒ No X |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4631 Araby Church Road | 21704 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married XX 3 ☐ Widowed 4 ☐ Divorced | 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-1946 | 1 ☐ Yes 2 ☒ No XX Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Bailiff | District Court |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Grover C. Smith | Nellie Rippeon |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Julia J. Smith, wife | 4631 Araby Church Rd., Frederick, Md. 21704 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Mount Olivet Cemetery, | June 3, 2002 | Frederick, Md. |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| ▶ Richard E. Stray | M00255 | Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Type I Aortic Dissection

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cystic Medial necrosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | 28883 | 5/29/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. ANJum QAZI, 7610 CARROLL AVE. #440, TAKOMA PARK, MD. 20912

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 31 2002 | ▶ Barbara G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

# Certificate of Death

Reg. No. 2002 18593

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Donald Warren Stevenson
2. Date of Death Month / Day / Year: May 16 2002
3. Time of Death: 11:55 A M
4a. Facility Name *(If not institution, give street and number)*: 1909 Carrollton Rd.
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 570-36-6345
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 16, 1930
9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1909 Carrollton Rd.
10f. Zip Code: 21401
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1954-1973
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Naval Aviator
16b. Kind of Business/Industry: U.S. Navy

17. Father's Name *(First, Middle, Last)*: Kenneth L. Stevenson
18. Mother's Name *(First, Middle, Maiden Surname)*: Edith B. Holmes

19a. Informant's Name/Relationship *(Type, Print)*: Edna Stevenson / Spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1909 Carrollton Rd. Annapolis, MD 21401

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore Crematory
Date: 5/18/2002
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Michael J. Sloan
22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Fibrosis — 6 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

**Medical Certification; To Be Completed by Physician/Medical Examiner**

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: DM35494
29d. Date signed *(Month, Day, Year)*: 5/17/2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Resnick MD 606 Ridgely Ave Suite 121 Annapolis, MD

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 20 2002
32. Registrar's Signature: Deanna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is markad other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18594

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lucille E. Simmons

2. Date of Death: Month May Day 18, Year 2002

3. Time of Death: 11:15 AM

4a. Facility Name (If not institution, give street and number): Knollwood Manor Nursing Home

4b. City, Town, or Location of Death: Millersville

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 508-16-9488

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 10, 1923

9. Birthplace (State or Foreign Country): NE

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Odenton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 726 Thornwood Drive

10f. Zip Code: 21113

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accounting Work

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Unavailable

18. Mother's Name (First, Middle, Maiden Surname): Unavailable

19a. Informant's Name/Relationship (Type, Print): Miles Simmons/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 726 Thornwood Drive, Odenton, MD 21113

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial

Date: May 21, 2002

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: James E. Barranco

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park FuneralHome 495 Gov. Ritchie Hwy, Severna Park, MD 21146

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 6 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Brian C. Wallace MD

29c. License number: D31136

29d. Date signed (Month, Day, Year): MAY 21, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN C. WALLACE MD, 35 MILKSHAKE LN, ANNAPOLIS, MD 21403

**State Registrar**

31. Date filed (Month, Day, Year): MAY 24 2002

32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18595

Roy Sumpter

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Roy Sylvester Sumpter
2. Date of Death (Month, Day, Year): MAY 21 2002
3. Time of Death: 6:15 P.M.
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 233-30-5805
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 13, 1917
9. Birthplace (State or Foreign Country): WV

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 224 Cypress Creek Road
10f. Zip Code: 21146
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher/Construction Worker
16b. Kind of Business/Industry: Education/Construction

17. Father's Name (First, Middle, Last): Ivan T. Sumpter
18. Mother's Name (First, Middle, Maiden Surname): Ollie Gay

19a. Informant's Name/Relationship (Type, Print): Warner Sumpter/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8246 Fairwood Drive, Pasadena, MD 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Cemetery
Date: May 25, 2002
20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: James E. Barranco
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cerebrovascular accident – brain stem. — 2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D43977
29d. Date signed (Month, Day, Year): May 21 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Oregon Opening. 301 Hospital Drive. Glen Burnie MD. 21061.

**State Registrar**

31. Date filed (Month, Day, Year): MAY 24 2002
32. Registrar's Signature: Donna P Sparks

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18596

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| SADIE REBECCA SPARENBERG | MAY 22 2002 | 6:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ANNE ARUNDEL MEDICAL CENTER | ANNAPOLIS | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-32-2362 | 1☐M 2☒F | 94 Yrs. | | | APR. 16, 1908 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | QUEEN ANNE | CHESTER | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1401 QUEEN ANNE DRIVE | 21619 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | -0- | SALES CLERK | RETAIL SALES |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CYRUS DRIVER | BLANCHE MILLS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MADELINE LARMORE/ DAUGHTER | 1327 CALVERT RD., CHESTER, MD 21619 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | STEVENSVILLE CEMETERY | 5-25-2002 | STEVENSVILLE, MD |

21. Signature of Funeral Service Licensee: Chad M. Fellows

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD, CHESTER, MD 21619

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Colon cancer, stage IV | 4 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Breast cancer (History of)

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D58724 | 5/22/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anne Arundel Medical Center, Annapolis, Maryland

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 23 2002 | [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM#11 per inf G812 100802 ss

Reg. No. 2002 18597

William Stevens

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| WILLIAM SEAFORD STEVENS, SR. | May 15, 2002 | 1300 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Memorial Hospital | Easton | Talbot |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-12-3741 | 1☒M 2☐F | 87 Yrs. | | | OCT. 14, 1914 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | QUEEN ANNE'S | CHESTER | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1623 POSTAL ROAD | 21619 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 5 | -0- | MAINTENANCE WORKER | STATE OF MARYLAND |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| IRA STEVENS | LOTTIE CLOUGH |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MARY ANN COURSEY/ DAUGHTER | 8319 BROADNECK RD, CHESTERTOWN, MD 21620 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | STEVENSVILLE CEMETERY | 5-18-2002 | STEVENSVILLE, MD |

21. Signature of Funeral Service Licensee ▶ Neal M. Helfenbein

22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUENRAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration Pneumonitis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dehydration

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ Dennis Deshields | D0053110 | 5/16/2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DENNIS DESHIELDS, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 20 2002 | ▶ S. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18598

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rita Ann Scott

2. Date of Death: Month May, Day 26, Year 2002

3. Time of Death: 5:40AM

4a. Facility Name (If not institution, give street and number): 27852 Greenwood Road

4b. City, Town, or Location of Death: Denton

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 215-50-6588

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 9, 1947

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Denton

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 27852 Greenwood Road

10f. Zip Code: 21629

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator

16b. Kind of Business/Industry: Day Care Provider

17. Father's Name (First, Middle, Last): Paul Scott

18. Mother's Name (First, Middle, Maiden Surname): Myrtle Ann Neal

19a. Informant's Name/Relationship (Type, Print): Christi McDowell Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11766 McDowell Lane, Greenwood, Delaware 19950

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Concord Cemetery

Date: 5/29/02

20c. Location - City or Town, State: near Denton, Maryland

21. Signature of Funeral Service Licensee: Randolph L. Moore

22. Name and Address of Facility: Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Cancer — Due to (or as a consequence of): — 1 year 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one) — Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature]

29c. License number: D29302 4

29d. Date signed (Month, Day, Year): 5/29/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David H. Smith, M.D., 29466 Pintail Drive, Easton, Maryland 21601

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAY 2 9 2002

32. Registrar's Signature: Donna D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No: 2002 18599

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: INEZ P. SKEETE
2. Date of Death — Month: MARCH Day: 7 Year: 2002
3. Time of Death: 7.30 AM
4a. Facility Name *(If not institution, give street and number)*: Prince Georges General
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 123-01-4468
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 8 1914
9. Birthplace *(State or Foreign Country)*: GUYANA

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: NEW CARROLLTON
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 7630 RIVERDALE RD
10f. Zip Code: 20784
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12+ / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SEAMSTRESS
16b. Kind of Business/Industry: GARMENT

17. Father's Name *(First, Middle, Last)*: Alexander Benjamin Mayers
18. Mother's Name *(First, Middle, Maiden Surname)*: MAUDE HAMILTON

19a. Informant's Name/Relationship *(Type, Print)*: HYACINTH SKEETE (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7630 RIVERDALE RD. NEW CARROLLTON MD 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. OLIVET CEMETERY
Date: 3/18/02
20c. Location - City or Town, State: WASHINGTON, DC

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: 716 Kennedy St. N.W. Washington DC. 20011

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | CARDIAC ARREST 2° TO BLOOD LOSS | 15-28 MINS |
| Due to (or as a consequence of): b. | BRADYCARDIA 2° TO EXANGUINATION | 15-28 MINS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | ABNORMAL COAGULATION PROFILE | 48 HRS. |
| Due to (or as a consequence of): d. | CONGESTIVE HEART FAILURE | 48 HRS. |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SUBENDOCARDIAL INFARCT. CHRONIC PULMONARY DISEASE

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: [signature] Samuel W. Alleyne
29c. License number: 25766
29d. Date signed *(Month, Day, Year)*: 4/30/02

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SAMUEL W. ALLEYNE. 6021 LANDOVER RD #8 CHEVERLY MD. 20785

**State Registrar**

31. Date filed *(Month, Day, Year)*: JUN 10 2002
32. Registrar's Signature: [signature] B Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18600

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| John F. Stewart Sr. | May 27, 2002 | 8:30 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Southern Maryland Hospital | Clinton | Prince Georges |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-16-0042 | 1 X M 2 ☐ F | 79 Yrs. | | | October 23, 1922 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince Georges | Brandywine | 1 ☐ Yes 2 ☐ No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| P.O. Box 261 | 20613 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorced | 1 ☐ Yes XX No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Electrician | Federal Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Francis Stewart | Carrie Watson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Brent Stewart/Son | 16500 Brandywine Road Brandywine, Maryland 20613 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Resurrection Cemetery | 5/31/02 | Clinton, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Lloyd Estep | 191 Adams Funeral Home P.A. Aquasco, Maryland |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardio-pulmonary Arrest | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Gram Possitive Staphylococc | |
| | Due to (or as a consequence of): c. Gram Possitive Bacteremia | |
| | Due to (or as a consequence of): d. Acute Renal Failure | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypovolemia, Hypokalemia, Anemia, CHF

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown | 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] Attending MD | D24208 | 5/28/2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ABU HASAN ANSARI MD 8926 Woodyard Rd Clinton MD 20735

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | [signature] |

**State Registrar**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 17 Rev 1/2001

ORIGINAL

Stewart Sr., John F 23a 5/29/02 @ 8:30 PM

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#23aperPHYG808 6/7/02 EW

# Certificate of Death

Reg. No. 2002 18601

Physician /Medical Examiner

Funeral Director

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Wasyl Soroka | April 29, 2002 | 3:30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Prince George's Hospital | Cheverly | Prince George's |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-42-9388 | 1 [X] M 2 [ ] F | 82 Yrs. | | | March 27,1920 | Poland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George's | Hyattsville | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3727 Thornwood Road | 20784 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 3 | | Custodian | Catholic Schools |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Unknown Soroka | Unknown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jerry Soroka / Son | 3727 Thornwood Road, Hyattsville, MD 20784 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Cedar Hill Cemetery | May 2, 2002 | Suitland, MD |

21. Signature of Funeral Service Licensee: Ken P. Thomas

22. Name and Address of Facility: Francis J. Collins Funeral Home,Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPTIC SHOCK | 6 hours |
| | Due to (or as a consequence of): | |
| | b. GANGRENE FEET | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | |
| | c. HYPERTENSION | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, Hypertension, Coronary Artery Disease

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [X] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Arvind M. Mehta MD | D27366 | 4/30/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ARVIND M. MEHTA 7100 Baltimore Ave #504 College Park MD 20740

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 01 2002 | G. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS #8,19a PER FH 6/3/02 CCHD DB

# Certificate of Death

Reg. No. 2002 18602

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EDGAR FRANCIS THOMPSON,JR.

2. Date of Death (Month Day Year): MAY 25,2002

3. Time of Death: 11:02 A.M.

4a. Facility Name (If not institution, give street end number): SOUTHERN MARYLAND HOSPITAL CENTER

4b. City, Town, or Location of Death: CLINTON

4c. County of Death: PRINCE GEORGES

**Funeral Director**

5. Social Security Number: 578-54-2441

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): ~~MARCH~~ FEBRUARY 24,1940

9. Birthplace (State or Foreign Country): WASHINGTON,DC

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: WALDORF

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 2009 ST.THOMAS STREET APT.120

10f. Zip Code: 20602

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OFFICE SUPERVISOR

16b. Kind of Business/Industry: HAUGHTON ELEVATOR CO

17. Father's Name (First, Middle, Last): EDGAR FRANCIS THOMPSON,SR.

18. Mother's Name (First, Middle, Maiden Surname): MAY ISAAC

19a. Informant's Name/Relationship (Type, Print): STEP DEBORAH THERRIEN-DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4835 KINGSTON DR. ANNANDALE,VA. 22003

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): METROPOLITAN CREMATORY

Date: 5-30-02

20c. Location - City or Town, State: ALEXANDRIA,VA.

21. Signature of Funeral Service Licensee: MO0479 Michael O. Raymond

22. Name end Address of Fecility: RAYMOND FUNERAL SERVICE,P.A. LA PLATA,MARYLAND 20646

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Athorosclerotic Cardiovascular Vent Disease

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physicien**: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner as steted. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvester MD

29c. License number: H0055927

29d. Date signed (Month, Day, Yeer): May 29, 2002

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): SALVADOR SYLVESTER 3001 Hospital Dr. Cheverly, md. 20785

**State Registrar**

31. Date filed (Month, Day, Yeer): MAY 30 2002

32. Registrer's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2002 18603

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: DONA MAE TALBOTT

2. Date of Death: Month MAY Day 27 Year 2002

3. Time of Death: 9:30 AM

4a. Facility Name *(If not institution, give street and number)*: 12900 Monroe Avenue

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 550-40-1892

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 3 1934

9. Birthplace *(Stete or Foreign Country)*: Wisconsin

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Prince George's

10c. City, Town or Location: Fort Washington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12900 Monroe Avenue

10f. Zip Code: 20744

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles Dasher

18. Mother's Name *(First, Middle, Maiden Surname)*: Lavern Dasher

19a. Informant's Name/Relationship *(Type, Print)*: Pearson Talbott Jr(husband)

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 12900 Monroe Ave Fort Washington, MD 20744

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Trinity Memorial Gardens

Date: 5-31-02

20c. Location - City or Town, State: Waldorf, MD

21. Signature of Funeral Service Licensee: John A. Eberwein M00173

22. Name and Address of Facility: Eberwein Funeral Services 4433 White Pls La White Pls., MD 20695

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Breast Cancer, Stage II B — 1 yr 6mo

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest

b. Due to (or as e consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Kai Yeung MD

29c. License number: D/47730

29d. Date signed *(Month, Day, Year)*: 5/29/02

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): 8926 Woodyard Road #201 Clinton, MD 20735 Kai Yiu Yeung

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAY 30 2002

32. Registrar's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

# Certificate of Death

Reg. No. 2002 18604

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| DONALD E. THOMAS | MAY | 25 | 2002 | 4:20 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ASBURY-SOLOMONS ISLAND HEALTH CARE | SOLOMONS | CALVERT |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 313-20-3800 | 1☒M 2☐F | 77 Yrs. | | | NOV. 11, 1924 | INDIANA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | CALVERT | SOLOMONS | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11657 ASBURY CIRCLE | 20688 | U. S. A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | JOURNALIST / WRITER | U. S. GOVERNMENT |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| LEWIS EASPERN THOMAS | MARIE ANTOINETTE BRIDGEWATER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| BETTY H. THOMAS / WIFE | 11657 ASBURY CIRCLE BOX 558 SOLOMONS, MD 20688 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | BRINSFIELD-ECHOLS CR. | MAY 26, 2002 | CHARLOTTE HALL, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| David C. Echols M00545 | BRINSFIELD-ECHOLS FUNERAL HOME, PA 30195 THREE NOTCH RD CHARLOTTE HALL, MD 20622 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Recurrent Aspiration Pneumonia

Due to (or as a consequence of):

c. Progressive Dementia

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D33123 | 5-7-02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JONATHAN LOWENTHAL, M.D. 1900 HOSPITAL RD PRINCE FREDERICK, MD 20678

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | Geneva B. Lewis |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended#1 perMD FCHD,KS 5310 **Certificate of Death** Reg. No. 2002 18605

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROGER EUGENE THOMPSON
2. Date of Death Month Day Year: MAY 19 2002
3. Time of Death: 1.59p M
4a. Facility Name (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

**Funeral Director**

5. Social Security Number: 220-28-3464
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 5, 1933
9. Birthplace (State or Foreign Country): FREDERICK, MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: FREDERICK
10c. City, Town or Location: FREDERICK, MARYLAND
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 337 SOUTH MARKET ST.
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10TH Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired): CONSTRUCTION
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): WILLIAM A. THOMPSON
18. Mother's Name (First, Middle, Maiden Surname): BLANCHE FREDERICKS

19a. Informant's Name/Relationship (Type, Print): DOTTIE THOMPSON (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21701: 337 SOUTH MARKET St. FREDERICK, MD.

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FAIRVIEW Cemetery
Date: 5-25-02
20c. Location - City or Town, State: FREDERICK, MD.

21. Signature of Funeral Service Licensee: ▶ Gary L. Rollins
22. Name and Address of Facility: GARY L. ROLLINS F/H 110 WEST SOUTH ST. Frederick, MD. 21701

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — weeks
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Pulmonary embolism — weeks
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Lung mass, presumed cancer

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D47169
29d. Date signed (Month, Day, Year): 5-19-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHAN-HING HO 610 9TH AVE., BRUNSWICK, MD 21716

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002
32. Registrar's Signature: ▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18606

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Virgie Trump

2. Date of Death: Month May, Day 21, Year 2002

3. Time of Death: 9:45 A M

4a. Facility Name (If not institution, give street and number): Northampton Manor Nursing Home

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 212-38- 9773

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 29, 1910

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5860 Genesis Lane Apt. 426

10f. Zip Code: 21701

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Oscar Summers

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Bonnie Harris/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5701 Trail View Court Apt.43-A/Frederick, MD 21703

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Mem. Gardens

Date: 5/24/2002

20c. Location - City or Town, State: Frederick, MD

21. Signature of Funeral Service Licensee: Raymond Stevens

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/Frederick, MD 21702

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Lung Disease — 10 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA,

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James S. Grision MD

29c. License number: D21944

29d. Date signed (Month, Day, Year): 5/21/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James S. Grision 1475 TANEY AVE #204 FREDERICK, MD 21702

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature: Barbara B Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18607

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROSA TILLER
2. Date of Death: Month May Day 15 Year 2002
3. Time of Death: 11:36 AM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

**Funeral Director**

5. Social Security Number: 418-42-5918
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 17 1930
9. Birthplace (State or Foreign Country): Alabama

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5580 Thunder Hill Rd.
10f. Zip Code: 21045
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Child Care Provider
16b. Kind of Business/Industry: Playhouse Day Care

17. Father's Name (First, Middle, Last): Joe Durden
18. Mother's Name (First, Middle, Maiden Surname): Atlean Sellen

19a. Informant's Name/Relationship (Type, Print): Rita Tiller(Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5580 Thunder Hill Rd. Columbia, Md. 21045

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory, or other place): Md. National Memorial Park
Date: 5/21/02
20c. Location - City or Town, State: Laurel, Md.

21. Signature of Funeral Service Licensee: Harry M. Reese M00482
22. Name and Address of Facility: Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LIVER FAILURE — TWO WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. HEPATITIS C INFECTION — TEN YEARS
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SUBDURAL HEMORRHAGE — DIABETES MELLITUS
RENAL FAILURE — HYPERTENSION
CONGESTIVE HEART FAILURE — DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Jeffrey A. Rumbaugh, MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): MAY 15, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEFFREY A. RUMBAUGH, MD 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287

**State Registrar**

31. Date filed (Month, Day, Year): MAY 21 2002
32. Registrar's Signature: [signature]

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ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then 'natural', or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18608

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Claire Patricia Tartasky

2. Date of Death: Month May Day 21, Year 2002

3. Time of Death: 7:30 p M

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 083-36-4901

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): Feb. 3, 1945

9. Birthplace (State or Foreign Country): NY

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 524 Bay Green Drive

10f. Zip Code: 21012

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. White Specify:

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ___ College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clinical Social Worker

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Richard Shanley

18. Mother's Name (First, Middle, Maiden Surname): Catherine Campbell

19a. Informant's Name/Relationship (Type, Print): Donald Tartasky/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 524 Bay Green Drive, Arnold, MD 21012

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veterans Cemetery

Date: May 24, 2002

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Barnes E. Barranco

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. metastatic cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. malignant melanoma — 1 month

Due to (or as a consequence of):

c. ___

Due to (or as a consequence of):

d. ___

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) ___ 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Curtis Harris, MD

29c. License number: D53306

29d. Date signed (Month, Day, Year): 5/22/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Curtis Harris, MD 600 Ridgely Ave Ste 231 Annapolis MD 21401

**State Registrar**

31. Date filed (Month, Day, Yeer): MAY 24 2002

32. Registrar's Signature: Donna D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18609

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month / Day / Year) | 3. Time of Death |
|---|---|---|
| Norval Edward Willey | May 24 2002 | 5:45 a.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 722 Glasgow Street | Cambridge | Dorchester |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-16-5811 | 1☒M 2☐F | 79 Yrs. | | | Aug. 2, 1922 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Dorchester | Cambridge | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 722 Glasgow Street | 21613 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | truck driver | fuel distributor |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Henry Lloyd Willey | Lydia Nora Fisher |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Laura R. Willey - wife | 722 Glasgow St., Cambridge, MD 21613 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | East New Market Cemetery | 5/28/02 | East New Market, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ John A Draper | Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Anasarca. | 1 year |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Metastatic Carcinoma of the Colon | 7 years |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes
Coronary Heart Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D11284 | 5.28.02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANN R. WILKE, MD 400 MARYLAND AVE., CAMBRIDGE, MD 21613

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | ▶ Jeanne B. Lewis |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18610

Name: Joseph Charles Wilhide

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Joseph Charles Holcraft Wilhide, Sr.

2. Date of Death: Month May Day 21, Year 2002

3. Time of Death: 4:00 P.M.

4a. Facility Name (If not institution, give street and number): Reeders Memorial Home

4b. City, Town, or Location of Death: Boonsboro

4c. County of Death: Washington

5. Social Security Number: 219-12-1401

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 22, 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Sharpsburg

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 2801 Harpers Ferry Road

10f. Zip Code: 21782

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Beverage

17. Father's Name (First, Middle, Last): Ernest C. Wilhide, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mabel E. Long

19a. Informant's Name/Relationship (Type, Print): Joseph C. Wilhide, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2809 Harpers Ferry Road Sharpsburg, Maryland 21782

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: May 24,2002

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerosis

Peripheral vascular disease.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D44996

29d. Date signed (Month, Day, Year): May 21, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Zafar Malik 20311 Lappans Road Boonsboro, Maryland 21713 301-432-8470

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature: [signature]

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18611

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Cornelius Alfred Watkins, Jr. | May 21 2002 | 23:25 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Shady Grove Adventist Hospital | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 336-09-3623 | 1 [X] M 2 [ ] F | 90 Yrs. | | | March 14, 1912 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Clarksburg | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 22701 New Cut Road | 20871 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Farmer | Farming |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Cornelius Alfred Watkins, Sr. | Laura Woodfield |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18644 |
|---|---|
| Albert S. Harris, Jr. - Nephew | 250 East Pettebone Street, Wyoming, Pennsylvania |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Upper Seneca Cemetery | May 25, 2002 | Germantown, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Olin L. Molesworth | Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Dehydration | 7 days |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Sepsis | 7 days |
| Due to (or as a consequence of): | | |
| | c. Aspiration Pneumonia | 7 days |
| Due to (or as a consequence of): | | |
| | d. Cerebrovascular Accident | 7 days |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| Farzad Assar M.D. | D-40201 | May 22, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FARZAD ASSAR 19251 MONTGOMERY VILLAGE, SUITE F-24, GAITHERSBURG, MD 20886

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**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | Geneva G Sparks |

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ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended#8perFH FCHD,KS 6/3/02 **Certificate of Death** Reg. No. 2002 18612

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Sandra Jean Wivell

2. Date of Death Month Day Year: May 30, 2002

3. Time of Death: 11:50 A M

4a. Facility Name (If not institution, give street and number): 11919 Taneytown Pike

4b. City, Town, or Location of Death: Taneytown

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 217-56-0276

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 51 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~NOV. 4, 1951~~ NOV. 4, 1950

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Taneytown

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 11919 Taneytown Pike

10f. Zip Code: 21787

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accounting Department

16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): Harry C. Sayler

18. Mother's Name (First, Middle, Maiden Surname): Margaret Clem

19a. Informant's Name/Relationship (Type, Print): Samuel Wivell / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11919 Taneytown Pike/ Taneytown, MD 21787

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Frederick Crematory

Date: 06/01/2002

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Raymond Peterson

22. Name and Address of Facility: Stauffer Funeral Home 140 E. Main St./ Thurmont, Maryland 21788

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Malignant Mixed Mullerian

Due to (or as a consequence of): b. Tumor of the ovary — 5 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: OS 066466 E

29d. Date signed (Month, Day, Year): 5/31/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy B. McInnness DO 25 Monument Rd Ste 120 York PA 17405

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002

32. Registrar's Signature:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FRED - 23a

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 | 8613

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Eleanor Ruth Welzel | 05 / 26 / 02 | 2245 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Western Maryland Hospital Center | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-24-1521 | 1☐M 2☒F | 74 Yrs. | | | Sept. 30, 1927 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 618 Maxwell Avenue | 21701 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Seamstress | Manufacturing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Eugene Carlisle, Sr. | Helen Colbert |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Carroll R. Wetzel / Husband | 618 Maxwell Avenue Frederick, Maryland 21702 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mt. Olivet Cemetery | May 30,2002 | Frederick, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Coronary artery Disease | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Atherosclerosis | years |
| | c. Due to (or as a consequence of): Diabetese mellitus | years |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure
Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D44496 | May 27, 2002 |

| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | |
|---|---|
| ZAFAR MALIK MD | 1500 Pennsylvania Avenue Hagerstown, MD 21742 |

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 31 2002 | ▶ [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18614

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ella Mae Wilson

2. Date of Death: Month MAY Day 11 Year 2002

3. Time of Death: 2 15 M

4a. Facility Name (If not institution, give street and number): Genesis Eldercare

4b. City, Town, or Location of Death: Severna Park

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 425-32-8022

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 20, 1922

9. Birthplace (State or Foreign Country): Mississippi

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 31 Hatton Drive

10f. Zip Code: 21146

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): High School Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): James E. Aycock

18. Mother's Name (First, Middle, Maiden Surname): Viola Moore

19a. Informant's Name/Relationship (Type, Print): J. Ford Wilson/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 31 Hatton Drive Severna Park, MD 21146

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem.

Date: May 14, 2002

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CARCINOMA — Approximate Interval: 2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

**Medical Certification: To Be Completed by Physician/Medical Examiner**

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D21776

29d. Date signed (Month, Day, Year): MAY 13 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURYA MUNDRA MD 3001 S HANOVER ST BALTIMORE 21230

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

**State Registrar**

31. Date filed (Month, Day, Year): MAY 15 2002

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18615

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOSEPH H. WILKERSON

2. Date of Death: Month MAY Day 15 Year 2002

3. Time of Death: 1:00 PM

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore, Md.

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 409-22-5019

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 22 1926

9. Birthplace (State or Foreign Country): TENNESSEE

Usual Residence of Decedent

10a. State: TENNESSE

10b. County: SHELBY

10c. City, Town or Location: MEMPHIS

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2146 RAYNER STREET

10f. Zip Code: 38106

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): 6 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER

16b. Kind of Business/Industry: MEMPHIS CITY SCHOOLS

17. Father's Name (First, Middle, Last): JOE WILKERSON

18. Mother's Name (First, Middle, Maiden Surname): WILLIE JEFFERSON

19a. Informant's Name/Relationship (Type, Print): DONALD WILKERSON (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3422 HIDDEN RIVER VIEW RD. ANNAPOLIS, MD. 21403

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): FOREST HILL CEMETERY

Date: 5/21/02

20c. Location - City or Town, State: MEMPHIS, TENNESSE

21. Signature of Funeral Service Licensee: Larry G. Reese #00483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST STREET ANNAPOLIS, MD. 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia — three days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Severe Dementia

Acute Renal Failure

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D50727

29d. Date signed (Month, Day, Year): May 15, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Gallagher 900 Caton Ave Baltimore, MD 21229

**State Registrar**

31. Date filed (Month, Day, Year): MAY 17 2002

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Joseph Wilkerson

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18616

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Leora Watkins

2. Date of Death: Month May Day 22, Year 2002

3. Time of Death: 9:00 a M

4a. Facility Name (If not institution, give street and number): FutureCare Chesapeake

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 213-12-9133

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Sept. 11, 1914

9. Birthplace (State or Foreign Country): WI

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 211 Doncaster Road

10f. Zip Code: 21012

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. White Specify:

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Unavailable

18. Mother's Name (First, Middle, Maiden Surname): Unavailable

19a. Informant's Name/Relationship (Type, Print): Jeff Watkins/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 211 Doncaster Road, Arnold, MD 21012

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: May 23, 2002

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas G. Allen

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — days

Due to (or as a consequence of):
b. dehydration — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. dementia — years

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

hypertension, osteoporosis
history of gastro intestinal bleeding

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D41955

29d. Date signed (Month, Day, Year): 5-22-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rebecca Don MD 479 Jumpers Hole Rd #304 Severna Park MD 21146

**State Registrar**

31. Date filed (Month, Day, Year): MAY 24 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18617

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Steven B. Whetzel | May 26, 2002 | 11:15 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-68-5855 | 1 X M 2 ☐ F | 44 Yrs. | | | Feb. 25, 1958 | Maryland |

**Usual Residence of Decedent**

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Avalon Shores | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1301 Hawthorne Street | 20764 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11th | | Carpenter | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Lester Whetzel | Edith Louise Dawson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Charles L. Whetzel/ Father | 1218 Daves Road Mayo, Maryland 21106 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Metropolitan Crematory | 5-27-02 | Alexandria, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septic Intra Abdominal Shock — 72hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dx Septic Katacholasis — year

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] Steven Resnick | DM35494 | 5/26/2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steve Resnick Anne Arundel Medical Center

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | [signature] |

**To be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18618

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Minnie Flortine Whitsett
2. Dete of Deeth: Month May Day 30 Year 2002
3. Time of Death: 0820
4e Fecility Name (If not institution, give street end number): 5484 American Corner Road
4b. City, Town, or Location of Deeth: Federalsburg
4c. County of Deeth: Caroline

**Funeral Director**

5. Sociel Security Number: 214-32-1464
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 68 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/03/34
9. Birthplace (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: MD
10b. County: Caroline
10c. City, Town or Location: Federalsburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 5484 American Corner Road
10f. Zip Code: 21632
10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 / College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Repair Woman/Elect.Assem.
16b. Kind of Business/Industry: Communications

17. Father's Neme (First, Middle, Lest): Norman L. Nichols, Sr.
18. Mother's Name (First, Middle, Maiden Sumeme): Ruth Thomas

19a. Informant's Name/Relationship (Type, Print): Charles Whitsett/Spouse
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 21632: 5484 American Corner Rd., Federalsburg, MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): East. Shore Vet. Cem
Date: 6/4/02
20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Feciliity: Framptom-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
e. Metastatic Breast Carcinoma — 24

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ [signature] MD
29c. License number: D35284
29d. Date signed (Month, Day, Year): 5/30/02

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): ANDREA ALLEN MD 720 Colonial Drive Denton MD 21629

**State Registrar**

31. Date filed (Month, Dey, Yeer): MAY 30 2002
32. Registrer's Signeture: ▶ Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18619

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| George Young Sr. | May 28, 2002 | 2:10 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| LAPLATA CENTER GENESIS ELDERCARE | LaPlata | Charles |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-22-0162 | 1 [X] M 2 [ ] F | 94 Yrs. | | | September 15, 1907 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Charles | Hughesville | 1 [X] Yes 2 [ ] No |

| 10e. Street end Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| P.O. Box 142<br>6460 Patuxent Wood Lane | 20637 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Farming | Agricultural |

| 17. Father's Neme (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Young | Agnes Campbell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| Dora Young/Wife | P.O. Box 142<br>6460 Patuxent Wood Lane Hughesville, Maryland 20637 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | St.Marys Cath. Ch. Cem. | 6/1/02 | Bryantown, Maryland |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| Lloyd Estep | 191 | Adams Funeral Home P.A. Aquasco, Maryland |

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)

a. ALZHEIMER'S DEMENTIA — x Months

Due to (or es a consequence of):

ADVANCED ATHEROSCLEROSIS — x years

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Wes an autopsy performed? | 24b. Were eutopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was cese referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpetient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| [signature] | D20129 | 5/28/02 |

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

GEORGE H. WATSON M.D. WALDORF, MD. 20603

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrer's Signature |
|---|---|
| MAY 30 2002 | [signature] G. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mantal Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has bean signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Pauline S. Yates
02-2570-033
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061102: ITEMS#23a,27 per ME C808 ss

# Certificate of Death

Reg. No. 2002 18620

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Pauline Mae Yates

2. Date of Death: Month May, Day 17, Year 2002

3. Time of Death: 7:05 P M

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George

**Funeral Director**

5. Social Security Number: 224-84-5609

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months, Days

If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Jan. 19, 1953

9. Birthplace (State or Foreign Country): Farmville, Va

Usual Residence of Decedent

10a. State: Md

10b. County: Prince George

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8704 Char Court #31

10f. Zip Code: 20708

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Washington Suburban Sanitation Co

17. Father's Name (First, Middle, Last): Charles F. Snyder

18. Mother's Name (First, Middle, Maiden Surname): Barbara Greaver

19a. Informant's Name/Relationship (Type, Print): Barbara G. Snyder, Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 351 Orchard Road, Burkeville, Va. 23922

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sunset Hill Cemetery

Date: 5-21-02

20c. Location - City or Town, State: Burkeville, Va.

21. Signature of Funeral Service Licensee: [signature] NO1113

22. Name and Address of Facility: 200 W CAROLINA AVE CREWE, VA JENNINGS-McMILLION Funeral Home

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. COMPLICATIONS OF CHRONIC ETHANOLISM

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): May 18, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**1- For State Registrar** — *Certificate of Death* — Reg. No. 2002 18621

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Casimer A. Aleksandrowicz
2. Date of Death: Month: June Day: 18 Year: 2002
3. Time of Death: 5:00A.M
4a. Facility Name (If not institution, give street and number): Genesis - Perring Pkwy. Nursing Home
4b. City, Town, or Location of Death: Parkville.
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-12-3053
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/4/17
9. Birthplace (State or Foreign Country): MA

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3523 Woodring Ave.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ForkLift Operator
16b. Kind of Business/Industry: Western Electric

17. Father's Name (First, Middle, Last): Konstantine Aleksandrowicz
18. Mother's Name (First, Middle, Maiden Surname): Kathryn Hajawska

19a. Informant's Name/Relationship (Type, Print): Helen B. Aleksandrowicz
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3523 Woodring Ave, Parkville, MD 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 6/13/02
20c. Location - City or Town, State: Parkville MD
21. Signature of Funeral Service Licensee: Krista S. Wells
22. Name and Address of Facility: Baltimore MD 21234 Evans Funeral Chapel 8800 Harford Rd.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Senile Dementia — Approximate Interval Between Onset and Death: years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ASCVD Obesity Sepsis Cardiac arrythmias s/p Pacemaker

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes [X] No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Martha Raymundo, MD
29c. License number: D54518
29d. Date signed (Month, Day, Year): 6-11-2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martha Raymundo, MD 3007 E. Northern Parkway Baltimore MD 21214

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

RR

RR ID

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

MEND ITEM #14 PER FH G808 6/19/02 JH — **Certificate of Death** — Reg. No. 2002 18622

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Armando Almanza
2. Date of Death: Month June Day 07, Year 2002
3. Time of Death: 5:28 p.m.
4a. Facility Name (If not institution, give street end number): 2142 Graythorn Road
4b. City, Town, or Location of Death: Middle River
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 459-52-3663
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 64 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): June 15, 1937
9. Birthplace (State or Foreign Country): Texas

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 2142 Graythorn Road
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Detes: 1955-1957
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No Specify: Mexican
14. Race - American Indian, Black, White, etc. Specify: ~~Hispanic~~ WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber
16b. Kind of Business/Industry: Plumbing

17. Fether's Neme (First, Middle, Lest): Librado Flores
18. Mother's Name (First, Middle, Maiden Surname): Elida Alamanza

19a. Informent's Name/Relationship (Type, Print): Sharon Almanza (Wife)
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 2142 Graythorn Road, Baltimore, Maryland 21220

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Md. Veterans Cemetery
Date: June 11, 2002
20c. Location - City or Town, State: Garrison Forest, Md.

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — 1 hour
Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last:
b. Due to (or as e consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier: Thomas J. Lynch MD
29c. License number: D42196
29d. Date signed (Month, Day, Year): June 8, 2002

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Thomas Lynch, MD 301 St. Paul Suite 907 Baltimore MD 21202

**State Registrar**

31. Dete filed (Month, Dey, Year): JUN 11 2002
32. Registrar's Signature:

**Baltimore, Maryland 21215-0036**

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the deeth certificate be executed within 24 hours after deeth.
**To the Funeral Director:** After this certificate has been signed by the attending physicien end completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2002 18623

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Charles Appling

2. Date of Death: Month 06 / Day 07 / Year 2002

3. Time of Death: 9:45am

4a. Facility Name (If not institution, give street end number): Maryland Masonic Homes

4b. City, Town, or Location of Death: Cockeysville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-01-5476

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): 12/13/1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 404 Rockfleet Road # 102

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): President

16b. Kind of Business/Industry: Calvert Coal Co.

17. Father's Name (First, Middle, Last): Edward Appling

18. Mother's Name (First, Middle, Maiden Surname): Gwendolyn Penning

19a. Informant's Name/Relationship (Type, Print): Susan Appling / daughter

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 404 Rockfleet Road # 102; Timonium, MD 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Hillton Service Corp.

Date: 6/8/02

20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: Patty V Ley

22. Name and Address of Facility: Ruck Towson Funeral Home, 1050 York Road, Towson, MD 21204

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebro VASculer Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Sip Stroke, Hypertension, Dementia, Dysphagia

23b. Did tobacco use contributa to tha causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Tibert, M.D.

29c. License number: D21464

29d. Date signed (Month, Dey, Yeer): 6/7/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L Tibert, MD. 3708 Bank St Balto, Md 21224

**State Registrar**

31. Date filed (Month, Day, Yeer): JUN 11 2002

32. Registrar's Signature: [signature]

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene.

**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rav 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18624

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Anne Kehl Allender | June 10, 2002 | 12:25 aM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Stella Maris | Timonium | Baltimore Co. |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-14-0302 | 1☐M 2☒F | 79 Yrs. | | | May 22, 1923 | Germany |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore Co. | Parkville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2914 D Kings Ridge Road | 21234 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 yrs. | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Wilhelm Kehl | Anna Nieman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Patrick W. Allender / son | 5 Holly Leaf Court Bethesda, Maryland 20817 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Moreland Mem. Park | 06/12/2002 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael E. Canapp | Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NON SMALL CELL LUNG CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No |
|---|---|

| 25. Was case referred to medical examiner? 1☐Yes 2☒No | 26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) HOSPICE |
|---|---|

| 27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D43725 | 6/10/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Exam must be notified at once.**

JUNE 10. 2002 12:25 a.m.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ANNE ALLENDER

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18625

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ethel M Bacon
2. Date of Death (Month, Day, Year): June 6 2002
3. Time of Death: 2:50 AM
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 236-52-7505
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 20, 1934
9. Birthplace (State or Foreign Country): West Virginia

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6902 Bradford Court
10f. Zip Code: 20707
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Post Office
16b. Kind of Business/Industry: U. S. Government

17. Father's Name (First, Middle, Last): Earl McComes
18. Mother's Name (First, Middle, Maiden Surname): Croy

19a. Informant's Name/Relationship (Type, Print): Karen Healey - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6902 Bradford Court, Laurel, Md. 20707

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD VA Cem. @ Cheltenham
Date: 6/11/02
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: Heather A. Brown
22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Rd., Laurel, MD 20707

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — Month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Pneumonia — 1 month
Due to (or as a consequence of):
c. Staph. Aureus Bacteremia — 1 month
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Adult Respiratory Distress Syndrome, Acute Renal Failure
Type II Diabetes Mellitus, Encephalopathy
Illeus, Acute Tubular Necrosis, Shock Liver Anemia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D46120
29d. Date signed (Month, Day, Year): June 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): F Deleon 10724 Little Patuxent Pkwy, Columbia MD 21044

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: Geraldine D. Sparks

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18626

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Mildred Gertrude Bender
2. Date of Death — Month: June; Day: 2; Year: 2002
3. Time of Death: 12:25 AM
4a. Facility Name *(If not institution, give street and number)*: St. Elizabeth Nursing & Rehab Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212-28-8055
6. Sex: 1 ☐ M 2 ☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs.
If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:
8. Date of Birth *(Month, Day, Year)*: May 27, 1911
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 595 Manor Road
10f. Zip Code: 21146
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Vincent J. Slavickas
18. Mother's Name *(First, Middle, Maiden Surname)*: Gertruda Slavickvite

19a. Informant's Name/Relationship *(Type, Print)*: Edward Bender / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 595 Manor Road, Severna Park, Maryland 21146

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Redeemer Cem.
Date: 6/4/2002
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dementia — 5 years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. A.S.C.V.D. — 10 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other *(specify)* 9 ☐ Unknown
23d. Date of delivery — Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier ▶ MD
29c. License number: D52746
29d. Date signed *(Month, Day, Year)*: June 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YELENA A. LIDNIK, MD. 720-C MAIDEN CHOICE LANE BALTIMORE, MD-21228

**State Registrar**

31. Date filed *(Month, Day, Year)*: JUN 11 2002
32. Registrar's Signature ▶ Brenda B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18627

**Physician /Medical Examiner**

**Funeral Director**

1. Decedent's Name *(First, Middle, Last)*: Annie J. Boardley
2. Date of Death (Month, Day, Year): June 6, 2002
3. Time of Death: 1:40 AM
4a. Facility Name *(If not institution, give street and number)*: Ruxton Health + Rehabilitation Ctr.
4b. City, Town, or Location of Death: Pikesville
4c. County of Death: Baltimore
5. Social Security Number: 216-20-8870
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 16, 1914
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 2121 Windsor Garden Lane #209
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress
16b. Kind of Business/Industry: Morgan + Millard's Rest.

17. Father's Neme *(First, Middle, Last)*: James Harris
18. Mother's Name *(First, Middle, Maiden Surname)*: Nora Brooks

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Christilia Higgs (daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5 Red Jonathan Ct. Pikesville, Md. 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arbutus Mem. Park — Date: 6/11/2002
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Chronic Hepatitis | 30 YRS |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significsnt conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Mann M.D.
29c. License number: D42561
29d. Date signed *(Month, Day, Year)*: 6/7/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martin Dassen, M.D. 21 Crossroads Dr. #400 Owings Mills, MD 21117

**State Registrar**

31. Date filed *(Month, Day, Year)*: JUN 11 2002
32. Registrer's Signature: Emma B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the death certificete be executed within 24 hours efter death.
**To the Funeral Director:** After this certificete hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18628

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): **Ralph Leslie Cupp**

2. Date of Death (Month, Day, Year): June 9, 2002

3. Time of Death: 4 a. M

4a. Facility Name (If not institution, give street and number): 3920 Southern Cross Drive

4b. City, Town, or Location of Death: Gwynn Oak

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 202-09-3311

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): February 16, 1916

9. Birthplace (State or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Gwynn Oak

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3920 Southern Cross Drive

10f. Zip Code: 21207

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steamfitter

16b. Kind of Business/Industry: Steamfitters and Plummers Local #438

17. Father's Name (First, Middle, Last): Harold Cupp

18. Mother's Name (First, Middle, Maiden Surname): Sarah Hamilton

19a. Informant's Name/Relationship (Type, Print): Mr. Jack E. Cupp (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1310 High Ridge Drive Westminster, MD 21157

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorail Park

Date: June 13, 2002

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Loring Byers Funeral Directors, 8728 Liberty Road Randallstown, Maryland 21133

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Lung Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Tobacco Use

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerosis

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 029085

29d. Date signed (Month, Day, Year): June 10 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allan J. Chacos M.D. 5310 Old Court Road 21133

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene 2002 18629

1- For State Registrar AMEND ITEM #20a PER FH G808 6/20/02 JH

# Certificate of Death

Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Roberta Chambers
2. Date of Death (Month, Day, Year): June 07 2002
3. Time of Death: 7:35P M
4a. Facility Name (If not institution, give street and number): Bon Secours Hospital of MD
4b. City, Town, or Location of Death: Baltimore MD
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 230-78-1138
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 47 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10 2 54
9. Birthplace (State or Foreign Country): VIRGINIA

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2411 ST STEPHENS CT APT-3D
10f. Zip Code: 21216
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: restaurant

17. Father's Name (First, Middle, Last): ROBERT ALLEN SR
18. Mother's Name (First, Middle, Maiden Surname): RACHEL AUSTIN

19a. Informant's Name/Relationship (Type, Print): RACHEL MATTHEWS-DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2411 ST STEPHENS CT APT-3C BALTO MD 21216

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): AUSTIN Family Cemetery — Date: JUNE 15, 2002
20c. Location - City or Town, State: DILLWYN, VIRGINIA

21. Signature of Funeral Service Licensee: Carlton C. Douglass
22. Name and Address of Facility: Carlton C. Douglass Funeral Service P.A. 1701 McCulloh St. Balto. Md. 21217

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — Approximate Interval Between Onset and Death: 2 wks
Due to (or as a consequence of):
b. Acute myocardial infarct — 2 wks
Due to (or as a consequence of):
c. Anoxic encephalopathy — 2 wks
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Seizure disorder

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Amatun M Nureem MD
29c. License number: D 15503
29d. Date signed (Month, Day, Year): June 10 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AMATUN M NUREEM 501 Dolphin St Balto MD 21217

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: Penny D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #1 PER PHY G808 6/28/02 JH

# Certificate of Death

2002 18630
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Nelia Mae ~~Daun~~ DAUN

2. Date of Death: Month June Day 10 Year 2002

3. Time of Death: 4:45 P M

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 302 14 3896

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): Dec. 20, 1924

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 106 Apt.#4 Kingsley Road

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Virgil Landreth

18. Mother's Name (First, Middle, Maiden Surname): Pearl Hamm

19a. Informant's Name/Relationship (Type, Print): Barbara Weber (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 110 Bladen Road Baltimore, Maryland 21221

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery Date: June 14, 2002

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: 24 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. SEPTIC SHOCK — 24 HOURS

Due to (or as a consequence of):
c. ___

Due to (or as a consequence of):
d. ___

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ___ 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Daniel Shimers MD

29c. License number: D53694

29d. Date signed (Month, Day, Year): 6/10/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. Daniel Shimers 9000 FRANKLIN SQUARE DR. BALTIMORE MD. 21237

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18631

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert, Dunn
2. Date of Death (Month, Day, Year): June 4 2002
3. Time of Death: 7:50 AM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

**Funeral Director**

5. Social Security Number: 216 62 4034
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): JAN. 31, 1956
9. Birthplace (State or Foreign Country): MARYLAND

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3402 FAIRMOUNT AVENUE
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAINTENANCE TECH
16b. Kind of Business/Industry: RUSCOMB GARDENS

17. Father's Name (First, Middle, Last): WILSON DUNN
18. Mother's Name (First, Middle, Maiden Surname): LOUISE WILLIAMS

19a. Informant's Name/Relationship (Type, Print): FRACRISA DUNN (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3402 e. fairmount aven. BALTO, MD. 21224

20a. Method of Disposition: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEM PK.
Date: JUNE 12, 2002
20c. Location - City or Town, State: BALTO, MD.

21. Signature of Funeral Service Licensee: Bernadine V. Scruggs
22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 e. preston ST. BALTO, MD. 21213

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Mucormycosis — 2 weeks
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Leukopenia — 8 years
Due to (or as a consequence of):
c. Pancytopenia — 8 years
Due to (or as a consequence of):
d. Large granular lymphocyte syndrome — 8 years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hepatitis C, latent tuberculosis

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Marjorie Patricia George, M.D.
29c. License number: RES-000
29d. Date signed (Month, Day, Year): June, 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marjorie Patricia George, 600 North Wolfe Street, Baltimore, Maryland, 21287

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: Geneva B. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For Steta Registrar

# Certificate of Death

Reg. No. 2002 18632

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| FRANKLIN | | EXLINE | JUNE | 6 | 2002 | 14 31 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 286-32-9710 | 1☒ M 2☐ F | 65 Yrs. | | | June 14, 1936 | Ohio |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Ohio | Athens | Glouster | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6888 Tunnel Road | 45732 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Laborer | Railroad |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Clyde Exline | Pearl Brunton |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Rocky Exline - Son | 6888 Tunnel Road, Glouster, Ohio 45732 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donetion 5☐ Other (Specify) | Maplewood Cemetery | 6/12/02 | Glouster, Ohio |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Heather A. Brown | Gary L. Kaufman Funeral Home 7250 Washington Blvd, Elkridge, MD 21075 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. AORTIC VALVE RUPTURE | 30 MINUTES |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. ATTEMPTED AORTIC VALVULOPLASTY | 1 HOUR |
| | Due to (or as a consequence of): c. SENILE CALCIFIC AORTIC STENOSIS | 2 YEARS |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SCLERODERMA

PULMONARY HYPERTENSION

CONGESTIVE HEART FAILURE

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒ Yes 2☐ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical exeminer? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MEDICAL DOCTOR | RES-000 | JUNE 8, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAL MELAMED 600 North Wolfe Street Baltimore Maryland 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD
02-2831-510
NOAH S.ENSOR

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar UNPENDED 062602:ITEMS#23a,27,28a-f per ME C808 ss

Reg. No. 2002 18633

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Noah Sebastian Ensor | MAY 29,2002 | 7:01P. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHNS HOPKINS HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-59-1124 | XX 1 M 2 F | 1 Yrs. | | | Feb 5, 2001 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | XX 1 Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3716 Chestnut Avenue | 21211 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| XX 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 XX No If Yes, Give Year or Dates: | 1 Yes XX No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| N/A | | Infant | N/A |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Warren Irvington Ensor, Jr. | Dawn Marie McDonaldson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dawn M. McDonaldson (Mother) | 3716 Chestnut Ave. Baltimore,MD 21211 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Lorraine Park Cem. | 6/3/2002 | Woodlawn,Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Joseph H. Carpenter | Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. DROWNING | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ☑ No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☑ Yes 2 No | 1 ☑ Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 XX Yes 2 No | Hospital: 1 Inpatient 2 XX ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 Natural 2 XX Accident 3 Suicide 4 Homicide 5 ~~Pending~~ investigation 6 Could not be determined | 5-29-02 | 6:09p M | 1 Yes 2 XX No | Subject drowned in pool |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| home | 1629 N. Calvert St., Baltimore, MD |

29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J Pestaner, M.D. | O.C.M.E. | MAY 30,2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | Bonnie D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18634

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Joseph William Figgs
2. Date of Death (Month, Day, Year): June 7, 2002
3. Time of Death: 12:30 P.M

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-16-7015
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 7, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 Yes 2 X No
10e. Street and Number: 26 Dunvale Road Apt D
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): clerk
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Joseph Figgs
18. Mother's Name (First, Middle, Maiden Surname): Ruth Jones

19a. Informant's Name/Relationship (Type, Print): Delma V. Figgs Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26 Dunvale Road, Apt D Towson, Maryland 21204

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Md Veterans' Cemetery
Date: 6/13/02
20c. Location - City or Town, State: Garrison Forest, MD

21. Signature of Funeral Service Licensee: Tracey H. Carpenter
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PHARYNX CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetaf death 3 Ectopic pregnancy 4 Pregnant at time ot death 5 Other (specify) 9 Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause ot death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No
26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D43725
29d. Date signed (Month, Day, Year): 6/7/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

JUNE 7, 2002 10:15 a.m.

JOSEPH FIGGS

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18635

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| JACK , FISH BEIN | June 6th 2002 | 8:05 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Howard County General Hospital | Columbia | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-22-6574 | 1 XX M 2 F | 91 Yrs. | | | OCT. 1, 1910 | POLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | HOWARD | COLUMBIA | 1 Yes XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5285 FIVE FINGERS WAY | 21045 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 XX Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | PROPRIETOR | HAIR CARE |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| ABRAHAM | FISHBEIN | SARAH | TRAFFACAN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| DARLA STROUSE / DAUGHTER | 9338 AFTERNOON LANE - COLUMBIA, MD 21045 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | OHEB SHALOM MEMORIAL PARK | 6/9/2002 | REISTERSTOWN, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Edward C Reisd | SOL LEVINSON 8900 REISTERSTOWN ROAD - PIKESVI |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 9 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. dehydration

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 ✓ No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 ✓ No | Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ✓ Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 ✓ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Rayan MD | D0053709 | June 6th 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAJ CHAWLA 3060 Mitchellville rd Bowie MD 20716

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | Penny B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural" or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18636

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Joseph Gurski
2. Date of Death: Month 06 Day 07 Year 2002
3. Time of Death: 1:45 AM
4a. Facility Name (If not institution, give street and number): Baltimore VA Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 211-22-2358
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 19, 1920
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3900 Loch Raven Blvd
10f. Zip Code: 21218
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1940-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Welder
16b. Kind of Business/Industry: Steel

17. Father's Name (First, Middle, Last): Victor Gurski
18. Mother's Name (First, Middle, Maiden Surname): Stella Murowski

19a. Informant's Name/Relationship (Type, Print): Valere A. Gurski - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 601 Maiden Choice Lane, Catonsville, Maryland 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: June 10,2002
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Ann Y. Zink
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Aspiration Pneumonia
Due to (or as a consequence of):
Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicef Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Igor Poltinnikov, MD
29c. License number: P15808
29d. Date signed (Month, Day, Year): 06-07-2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Igor M. Poltinnikov 10 N. Greene Street Baltimore, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "neturel', or Items 23a or 28a-f show any injury or other treumetic event, the Medical Exeminer must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospitel or Attending Physicien:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18637

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lucille Ann Gayhardt
2. Date of Death: Month 06 Day 09 Year 2002
3. Time of Death: 5:40 PM
4a. Facility Name (If not institution, give street and number): Charlestown Care Center
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-01-8543
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-12-1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 719 Maiden Choice Lane
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Billing Clerk
16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Arthur Pacy
18. Mother's Name (First, Middle, Maiden Surname): Lucille McGonigle

19a. Informant's Name/Relationship (Type, Print): James A. Gayhardt/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 812 Winchester Dr. West Minster, Maryland 21157

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 6-13-2002
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER — 4 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D44748
29d. Date signed (Month, Day, Year): June 10, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW V. NARRETT 711 Maiden Choice Lane, Baltimore, MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

# Certificate of Death

Reg. No. 2002 18638

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): STELLA GIARDINA

2. Date of Death: Month JUNE Day 7TH Year 2002

3. Time of Death: 4:20 A.M

4a. Facility Name (If not institution, give street and number): Howard County General

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 215-09-1160

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3-30-1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1104 Dorchester Avenue

10f. Zip Code: 21207

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify: XX

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Person

16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Louis V. Karko

18. Mother's Name (First, Middle, Maiden Surname): Patricia Chesnauskas

19a. Informant's Name/Relationship (Type, Print): Carolyn Keene

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5523 Oregon Avenue Baltimore, Maryland 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery

Date: 6-11-2002

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21228

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS — WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. RENAL FAILURE — WEEKS

Due to (or as a consequence of):

c. DEMENTIA — MONTHS

Due to (or as a consequence of):

d. PROBABLE ENDOCARDITIS — WEEKS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: SGupta M.D

29c. License number: D0053150

29d. Date signed (Month, Day, Year): JUNE 7TH 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHAKUNTALA GUPTA 201-109 BACK RIVER NECK RD BALTIMORE 21221

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18639

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Carl A. Gerkens
2. Date of Death Month: 06 Day: 07 Year: 2002
3. Time of Death: 7:12 A.M.
4a. Facility Name (If not institution, give street and number): 5113 Fawn Grove Road
4b. City, Town, or Location of Death: Pylesville
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 213-07-5466
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 20, 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Pylesville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 5113 Fawn Grove Road
10f. Zip Code: 21132
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. College (1-4or 5+): 1 yr.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed-Builder
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): John Gerkens
18. Mother's Name (First, Middle, Maiden Surname): Dorothea Unknown

19a. Informant's Name/Relationship (Type, Print): Carl J. Gerkens
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5111 Fawn Grove Road Pylesville Maryland 21132

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evans Funeral Chapel-Bel Air, P.A.
Date: June 7, 2002
20c. Location - City or Town, State: Forest Hill, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Evans Funeral Chapel-Bel Air, P.A. 21050 3 Newport Drive Forest Hill, Maryland

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. chronic obstructive pulmonary disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
chronic fibrillation

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David S. Dunn
29c. License number: D 32279
29d. Date signed (Month, Day, Yeer): June 7, 2002

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print): David S. Dunn, Gary W. MacPhail Bel Air MD

**State Registrar**

31. Dete filed (Month, Day, Year): JUN 11 2002
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified and ONLY**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

KR

RR 5

ADH
WAYNE MORGAN GUM
02-3069-005

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2002 18640

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Wayne Morgan Gum

2. Date of Death Month / Day / Year: JUNE 8, 2002

3. Time of Death: 10:45 PM

4a. Facility Name *(If not institution, give street and number)*: 9036 AVENUE B

4b. City, Town, or Location of Death: EDGEMERE

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 215-94-4955

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 38 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 3/8/1964

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Edgemere

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9036 Avenue B

10f. Zip Code: 21219

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales

16b. Kind of Business/Industry: MSC

17. Father's Name *(First, Middle, Last)*: Guy J. Gum

18. Mother's Name *(First, Middle, Maiden Surname)*: Janet Nida

19a. Informant's Name/Relationship *(Type, Print)*: Janet Gum/ Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 325 Lord Byron Lane Cockeysville MD 21030

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oaklawn Cemetery

Date: 6/13/02

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: Sandra Dittao

22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21237

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Self-inflicted Gunshot Wound of Chest

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* AT SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*: 6/8/02

28b. Time of Injury: 10:41 PM (Found)

28c. Injury at Work? 1 [ ] Yes 2 [✓] No

28d. Describe how injury occurred: Subject Shot Self

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Home

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 9036 Avenue B Edgemere, Maryland

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner, M.D.

29c. License number: OCME

29d. Date signed *(Month, Day, Year)*: JUNE 9, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: JUN 11 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #10f PER FH G808 6/11/02 TH

# Certificate of Death

Reg. No. 2002 18641

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|---|
| RAYMOND | GLASER | JUNE 8 2002 | 4:30 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| BROOKE GROVE REHAB & NURSING CENTER | SANDY SPRING | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-07-9719 | 1 X M 2 ☐ F | 88 Yrs. | | | JULY 15, 1913 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | MONTGOMERY | SILVER SPRING | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15310 BEAVERBROOK COURT | 20906 ~~SILVER SPRING~~ | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | CARTOGRAPHER | U.S. GOVERNMENT |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| I RAL | GLASER | BESSIE | SCHLOSSBERG |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| THELMA GLASER / WIFE | 15310 BEAVERBROOK COURT - SILVER SPRING, MD 20906 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | BETH TFILOH CONG. | 6/9/2002 | WOODLAWN, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Edward C. Rund | SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Small Bowel Obstruction | 2 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive pulmonary Disease
Prostate Cancer

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown | 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D43202 | June 8, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. Ozanne - Blankfard MD 3305 North Leisure World Blvd Silver Spring Maryland 20906

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18642

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Willie Harris

2. Date of Death: Month June, Dey 6, Year 2002

3. Time of Death: 2316pm

4e. Facility Name (If not institution, give street and number): Dorchester General Hospital

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 217-30-9569

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 7, 1935

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Mardela Springs

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 9785 Wallertown Road

10f. Zip Code: 21837

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator

16b. Kind of Business/Industry: Pepsi Cola Bottling Co.

17. Father's Name (First, Middle, Last): Willie Kellon Harris

18. Mother's Name (First, Middle, Maiden Surname): Nellie Levota Jackson

19a. Informant's Name/Relationship (Type, Print): Mrs. Betty Harris-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9785 Wallertown Road, Mardela Springs, MD 21837

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Wesley U. M. Ch. Cem.

Date: Jun 13 2002

20c. Location - City or Town, State: Vienna, MD

21. Signature of Funeral Service Licensee: Calvin L. [illegible]

22. Name and Address of Facility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: if item 27 is marked other than "natural", or items 23a or 26-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Probable Myocardial Infarction

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

Chronic Lymphocytic Leukemia

23b. **Did tobacco use contribute to the cause of death?** 1☑**Yes** 2☐**No** 3☐**Probably** 4☐**Unknown**

24a. Wes an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Jay D. Kerr, MD

29c. License number: D54840

29d. Date signed (Month, Day, Year): 6/7/02

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 503A Muir St, Cambridge MD 21613, Jay D. Kerr, MD

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: Brenda D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

02-2946-510
JOSEPH L.HICKS
RKD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18643

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOSEPH L. HICKS
2. Date of Death (Month, Day, Year): JUNE 4, 2002
3. Time of Death: 3:50P. M
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 214-40-8360
6. Sex: 1☐M 2☐F — XX
7. Age (In yrs. last birthday): 59 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5 27 43
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1830 E. Chase Street
10f. Zip Code: 21212
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Millennium

17. Father's Name (First, Middle, Last): George Hicks
18. Mother's Name (First, Middle, Maiden Surname): Carrie Moore

19a. Informant's Name/Relationship (Type, Print): Tammy L. Gant Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1264 Kitmore Road Baltimore MD 21239

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest
Date: 6-12-02
20c. Location - City or Town, State: OwingsMills MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: BALTIMORE MARYLAND 21202
MARCH F.H. EAST 1101 E. NORTH AVENUE

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: OBESITY

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒No 3☐ Probably 4☐Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JUNE 5,2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G.RIPPLE MD. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #10d PER FH G808 6/24/02 TH

# Certificate of Death

Reg. No. 2002 18644

Patient known As David Hummer

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| David Iden Hummer | June 01 2002 | 1:15 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore City | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-64-3527 | 1☒M 2☐F | 47 Yrs. | | | Oct. 4, 1954 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Pikesville | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7 Sudbrook Lane | 21208 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | flooring contractor | construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Iden Hummer | Hazel Irene Truitt |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ellen Baque - sister | 11408 Tall Forest Circle, Germantown, MD 20876 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Enders & Shirley Funeral Homes & Crematory | June 4, 2002 | Berryville, Virginia |

21. Signature of Funeral Service Licensee ▶ Clifton Enders

22. Name and Address of Facility: Columbia Mortuary Service, 306 Park Hall St., Laurel, Maryland 20724

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Ventricular Tachycardia | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, End Stage Renal Disease, Peripheral Vascular Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Neva Onilikon MD | RES-000 | June 01, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Neva Onilikon MD Sinai Hospital of Baltimore

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | ▶ Barbara D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10d

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18645

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| SANDRA | STEKL | HYNSON | June | 2 | 2002 | 21:00 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 391-26-9668 | 1☐M 2☒F | 73 Yrs. | | | | | September 11, 1928 | Wisconsin |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Keedysville | 1☐Yes 2☐No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4801 Toyer Road | 21756 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Clausen Francis Stekl | Marjorie Fisher |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard W. Hynson Husband | 4801 Toyer Road Keedysville, Maryland 21756 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Greenmount Cemetery | June 4, 2002 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Dennis Stephen Kenakis | Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | 1 WEEK |
| Due to (or as a consequence of): | b. HEPATIC FAILURE | 1 WEEK |
| Due to (or as a consequence of): | c. | |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALCOHOLISM, ACUTE RENAL FAILURE, OBESITY HYPOVENTILATION SYNDROME, HYPOTHYROIDISM

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D0056955 | 6/3/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BRIAN MCVERRY, MD THE JOHNS HOPKINS HOSPITAL, 1600 N. Wolfe St. BALTIMORE, MD 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural', or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospitel or Attending Physicien:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18646

Lorenzo Humphreys
Baltimore, Maryland 21215-0036

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lorenzo Dow Humphreys
2. Date of Death (Month, Day, Year): June 9, 2002
3. Time of Death: 11:30A M
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 235 46 1677
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 12, 1932
9. Birthplace (State or Foreign Country): West Virginia

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 568 Compass Road
10f. Zip Code: 21220
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1950-53
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Rate Setter
16b. Kind of Business/Industry: Bethlehem Steel Corp.
17. Father's Name (First, Middle, Last): Berlin F. Humphrey
18. Mother's Name (First, Middle, Maiden Surname): Lillie B. Goff
19a. Informant's Name/Relationship (Type, Print): Marie humphreys (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 568 Compass Road Middle River, Maryland 21220
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem.
Date: 6/12/2002
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — 72 Hours

Due to (or as a consequence of):
b. Pyelonephritis — 72 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease
Pulmonary Fibrosis

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] DO
29c. License number: P14552
29d. Date signed (Month, Day, Year): 6/9/2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Jeanette Krolikowski 9000 Franklin Square Drive Baltimore, MD. 21237

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: [signature]

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No: 2002 18647

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Florence Lorraine Harper | June 06, 2002 | 4:25 P.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1203 Robin Hood Circle | Baltimore | Baltimore County |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-88-5538 | 1☐M 2☒F | 89 Yrs. | | | November 16,1912 | Baltimore, Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore County | Baltimore | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1203 Robin Hood Circle | 21204 | United States of America |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 04 | Art Teacher | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Edward I. Gaskins | Violet Duvall |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. William J. McCarthy, Jr.(Attorney) | c/o Allfirst Trust Co. 25 South Charles St. Baltimore,MD. 21201 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Loudon Park Cemetery | 6/10/2002 | Baltimore, Maryland |

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr. — Jeffrey L. Gair, Sr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 18 months

Immediate Cause (Final disease or condition resulting in death): a. CARCINOMA OF LUNG

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Charles O'Donovan | D 12399 | JUNE 8, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES O'DONOVAN M.D. 6565 N. CHARLES ST. #509 BALTIMORE, MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | Regina B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 | 8648

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Sophia Izdebski | June 07 2002 | 7:40PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2460 Woodcroft Rd. | Parkville | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-18-5823 | 1☐M 2☑F | 90 Yrs. | | | July 24, 1911 | Poland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Parkville | 1☐Yes 2☑No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2460 Woodcroft Rd. | 21234 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☑Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Homemaker | Domestic |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| Joseph Jakubiak | Jilianna |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Angela Morgereth/ Daughter | 2460 Woodcroft Rd. Baltimore, Maryland 21234 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Holy Rosary Cemetery | June 11, 2002 | Baltimore Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶Kathleen Weber CFSP | David J. Weber Funeral Homes PA 401 S. Chester Street, Baltimore, Maryland 21231 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ADVANCED BREAST CARCINOMA | 24 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as e consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date Signed (Month, Dey, Year) |
|---|---|---|
| ▶ MD H.S. Ila | D30149 | 6/10/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1505 Osler Dr. Suite 302 Towson, MD 21204

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | ▶ Jeanne B. Sparks |

**State Registrar**

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18649

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Marie Helen Jones

2. Date of Death: Month June, Day 8, Year 2002

3. Time of Death: 1:45 AM

4a. Facility Name (If not institution, give street and number): St. Elizabeth's Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-62-4916

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 102 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): Feb 10, 1900

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1044 Downton Road

10f. Zip Code: 21227

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): John Evans

18. Mother's Name (First, Middle, Maiden Surname): Ruth unknown

19a. Informant's Name/Relationship (Type, Print): Charles R. Jones - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5601 Huntsmoor Road, Arubutus, Maryland 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: June 11,2002

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular accident — Approximate Interval Between Onset and Death: 1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) ___ 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: 052746

29d. Date signed (Month, Day, Year): June, 10, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Yelena Lipnik, 720 Marden Chase Lane, Bel Air MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: [signature]

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then 'natural', or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospitel or Attending Physicien:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #5 PER FH G808 6/11/02 JH **Certificate of Death**

Reg. No. 2002 18650

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Yeer | 3. Time of Death |
|---|---|---|---|---|
| Patsy Ann Johnson | JUNE | 7, | 2002 | 1720 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Stella Maris at Mercy Hospital | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| ~~217~~-34-1514 287 | 1☐M 2☒F | 61 Yrs. | | | Jul 3, 1940 | VA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1528 Latrobe Park Terr. | 21230 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Malcoln Rhodes | Annie Frances Johnson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Arlene Snow/Daughter | 1513 E. Fort Avenue, Baltimore, MD 21230 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | Jun 10 2002 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] M00980 | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Lung Cancer | 2½ years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Cancer
Arthritis

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) Stella Maris at Mercy |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

| 29a. Certifier (Check only one) | 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|---|
| 1☐~~Certifying Physician~~: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | ▶ [signature] | D40854 | JUNE 7, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID RISEBERG 301 St Paul Pl, BALTIMORE MD 21202

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | [signature] |

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18651

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARGARET Johnson
2. Date of Death: Month JUNE Day 7 Year 2002
3. Time of Death: 00:40 AM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE.

**Funeral Director**

5. Social Security Number: 215-24-3215
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10 15 12
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 631 Leafydale Terr.
10f. Zip Code: 21208
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): License Prac. Nurse
16b. Kind of Business/Industry: Univ. Of MD Hosp.

17. Father's Name (First, Middle, Last): Jeremiah Chambers
18. Mother's Name (First, Middle, Maiden Surname): Stella Rhodes

19a. Informant's Name/Relationship (Type, Print): Ruth Watkins Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 631 Leafydale Terr. Pikesville Maryland 21208

20a. Method of Disposition: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Calvary Cemetery
Date: 6-13-02
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: ▶ Gladys Warner
22. Name and Address of Facility: BALTIMORE MAAYLAND 21202 MARCH F.H. EAST 1101 E. NORTH AVENUE

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. RECTAL CARCINOMA.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: 1. HYPERTENSION'

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ PHYSICIAN
29c. License number: D 42723
29d. Date signed (Month, Day, Year): JUNE 7 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AVVERAHALLI M HARISH. NORTHWEST HOSPITAL CENTER 5401 OLD COURT ROAD. MD 21133.

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18652

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY WHITE JOHNSON
2. Date of Death (Month, Day, Year): JUNE 8, 2002
3. Time of Death: 10:10 P. M
4a. Facility Name (If not institution, give street and number): 800 Southerly Road
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 020-09-7054
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-15-1909
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 800 Southerly Road
10f. Zip Code: 21286
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5 Plus
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Arthur Newhall Johnson
18. Mother's Name (First, Middle, Maiden Surname): May Louise Ash

19a. Informant's Name/Relationship (Type, Print): William F. Blue (ATTORNEY)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 409 WASHINGTON AVENUE, Towson, Maryland, 21204

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Pine Grove Cemetery
Date: 06-14-2002
20c. Location - City or Town, State: LYNN, Massachusetts

21. Signature of Funeral Service Licensee: R. H. Ruck
22. Name and Address of Facility: Ruck Towson Funeral Home Inc. 1050 York Road, Towson, Maryland, 21204

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. pneumonia — 10d

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. arteriosclerotic disease — 5 yrs
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D29769
29d. Date signed (Month, Day, Year): 6/10/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 516 N. Rolling Rd Baltimore Md 21228

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18653

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| HANNAH | JOFFE | JUNE 7 2002 | 20:25P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 7025 CONCORD ROAD | BALTIMORE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-40-2510 | 1☐M 2☒F | 97 Yrs. | | | JULY 14,1904 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7025 CONCORD ROAD | 21208 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | TEACHER | HIGH SCHOOL EDUCATION |
| | 5+ | | |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| ABRAHAM | JOFFE | RACHAEL | BLUMBERG |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| BENJAMIN JOFFE / BROTHER | 7025 CONCORD ROAD - BALTIMORE, MD 21208 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | HEBREW FRIENDSHIP | JUNE 9,2002 | BALTIMORE, MD. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Dehydration | 2 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Dementia | years |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D 54717 | 6/8/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAMEEN MOLAVI MD 10755 FALLS RD. SUITE 470 Lutherville MD 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #27 PER ME G808 6/20/02 JH

# Certificate of Death

Reg. No 2002 18654

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Koenig

2. Date of Death Month: June Day: 8 Year: 2002

3. Time of Death: 11:17AM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-10-6762

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8-13-1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 1402 McCurley Avenue

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Baker

16b. Kind of Business/Industry: Whole sale bakery

17. Father's Name (First, Middle, Last): Henry Koenig

18. Mother's Name (First, Middle, Maiden Surname): Anna Rose Flathmann

19a. Informant's Name/Relationship (Type, Print): Norman E. Koenig/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2953 Beaver Brook Court Pasadena, Maryland 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loundon Park Cemetery

Date / 20c. Location - City or Town, State: 6/12/2002 Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. pulmonary embolism — hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. hypertension

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: hip fracture

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): May 24, 2002

28b. Time of Injury: unknown

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Syncopal episode at home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home

28f. Location (Street and Number or Rural Route Number, City or Town, State): Baltimore, Maryland

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeffrey Briggs MD

29c. License number: D 28640

29d. Date signed (Month, Day, Year): June 9, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2414 Hightee Ct. Crofton Md 21114 Jeffrey Briggs, MD

State Registrar

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18655

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): SARAH KIM

2. Date of Death (Month, Day, Year): JUNE 7 2002

3. Time of Death: 1357 M

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

**Funeral Director**

5. Social Security Number: 220-23-2483

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 13 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 21 1989

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 26 Westminster Bridge Way

10f. Zip Code: 21093

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Korean

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+): —

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): Hae S. Kim

18. Mother's Name (First, Middle, Maiden Surname): Mi Kyung Kim

19a. Informant's Name/Relationship (Type, Print): Hae S. Kim

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26 Westminster Bridge Way Lutherville, Md 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem

Date: June 10 2002

20c. Location - City or Town, State: Timonium, Md

21. Signature of Funeral Service Licensee: Krista L Wells

22. Name and Address of Facility: Evans Funeral Chapel 2325 York Rd Timonium, Md 21093

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. HYPOTENSION — one week

Due to (or as a consequence of):

c. SEPSIS — one week

Due to (or as a consequence of):

d. LEUKEMIA — 2 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

NEUTROPENIA

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carolyn Boylan MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): June 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carolyn Boylan, MD 600 N. Wolfe St. Baltimore MD 21287

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: Jennifer B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18656

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| HOWARD | KLEMM | June 07 2002 | 3:55 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-14-4081 | 1 X M 2 ☐ F | 81 Yrs. | | | April 30, 1921 | MD. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md | Baltimore | Dundalk | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 503 Fairview Avenue | 21224 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12yrs | 2 yrs | Plumber | Plumbing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John C. Klemm | Delia E. Wells |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Clara E. Klemm wife | 503 Fairview Avenue, Dundalk, Md. 21224 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Oak Lawn Cemetery | June 10, 2002 | Dundalk, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Anthony C. Connelly | Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, DUndalk, Md. 21222 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Stroke | 6 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 X No |

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Jacob Schwarz MD | RES-000 | June 7, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jacob Schwarz Johns Hopkins Hospital 600 North Wolfe Street Baltimore Maryland 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | Bernice B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18657

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| STEPHEN | M. | KANIS | JUNE 10, 2002 | 6.00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 101 CHALMERS AVENUE | FERNDALE | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 208-07-4779 | 1☒ M 2☐ F | 87 Yrs. | | | APRIL 8, 1915 | PA. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | GLEN BURNIE | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 101 CHALMERS AVENUE | 21061 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married ☒☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | ELECTRICIAN | ELECTRICIAL SONSTRUCTION |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOHN KANIS, SR. | ANNA PAVELEK |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| BONNIE KANIS (DAUGHTER) | 101 CHAMERS AVENUE, GLEN BURNIE, MD. 21061 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | GLEN HAVEN MEMORIAL PARK | JUNE 12, 2002 | GLEN BURNIE, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC CANCER OF COLON | 3 months |
| Due to (or as e consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. CANCER OF COLON | 2 Years |
| Due to (or as a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ S. Jassi M.D. | D54292 | June 10th 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. JASSI 1600 CRAIN HIGHWAY Suite 201, GLEN BURNIE, MD 21061

**Division of Vital Records, P.O. Box 68760,**

**To the Hospitel or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18658

2:23 am

6/6/02

Kahl, Marie

Baltimore, Maryland 21215-0020

K

10

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Marie Janet Kahl | June 6, 2002 | 2:23 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Gilchrist Center | Baltimore | Baltimore County |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-01-1902 | 1☐ M 2☒ F | 84 Yrs. | | | August 31, 1917 | Baltimore, Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore County | Baltimore | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8100 Rossville Boulevard Apt. 101 | 21236 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No *Specify:* | *Specify:* White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 Years | N/A | Owner - Kahl's Resturant | Resturant Industry |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Rudolf Batogowski | Stephanie Kitowski |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Henry Kahl (Son) | 2300 Franklins Chance Ct. Fallston, Maryland 21047 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | St. Joseph's Church Cemetery | June 8, 2002 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | Lassahn Funeral Home, Inc. 7401 BelAir Road Baltimore, Maryland 21236 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. Peritoneum cancer | months |
| | Due to (or es a consequence of): | |
| Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or es e consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Helen M Gordon MD | D0051926 | June 6, 2002 |

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)
Helen M. Gordon MD 6565 N. Charles St, Baltimore MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Yeer) | 32. Registrer's Signature |
|---|---|
| JUN 11 2002 | Geneva B Sparks |

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18659

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Loreine York Kendrick

2. Date of Death (Month, Day, Year): June 9, 2002

3. Time of Death: 9:25 AM M

4e. Facility Name (If not institution, give street and number): 10387 Launcelot Lane

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 579-12-6160

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 26, 1922

9. Birthplace (State or Foreign Country): New York

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 9672 Gwynn Park Drive

10f. Zip Code: 21042

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Translator

16b. Kind of Business/Industry: Voice of America

17. Father's Name (First, Middle, Last): Don H. York

18. Mother's Name (First, Middle, Maiden Surname): Lillian Gregg

19a. Informant's Name/Relationship (Type, Print): Pamela Taylor/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9672 Gwynn Park Drive Ellicott City, MD 21042

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 6-10-02

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC LUNG DISEASE — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DEMENTIA ALZHEIMER type — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HIGH CHOLESTEROL

OSTEOPOROSIS

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Assisted Living

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jay E Sealy MD

29c. License number: D25210

29d. Date signed (Month, Day, Year): June 10, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JERRY SEALS 10200 CHARTER DR. COL. MD

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: Barbara B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For Stete Registrar

Reg. No. 2002 18660

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): SAUL STEVEN KUSHNER

2. Date of Death: Month June Day 9th Year 2002

3. Time of Death: 5:35 AM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 096-14-9772

6. Sex: 1 XX M 2 ☐ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2/28/1923

9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Location: SEVERN

10d. Inside City Limits: 1 ☐ Yes XX No

10e. Street and Number: 1279 THOMPSON AVENUE

10f. Zip Code: 21144

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PHYSICIST

16b. Kind of Business/Industry: WESTINGHOUSE

17. Father's Name (First, Middle, Last): JOSEPH KUSHNER

18. Mother's Name (First, Middle, Maiden Surname): MINNIE LONDON

19a. Informant's Name/Relationship (Type, Print): ALICE KUSHNER - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1279 THOMPSON AVENUE SEVERN MARYLAND 21144

20a. Method of Disposition: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HOLY CROSS CEM.

Date: 6/11/02

20c. Location - City or Town, Stete: BALTIMORE, MD

21. Signature of Funeral Service Licensee: KELLY GREGORY FINK #MOT146

22. Name and Address of Facility: FINK FUNERAL HOME, PA 426 CRAIN HWY, S. GLEN BURNIE, MD 21061

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ruptured Septal distribution bifs

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case relerred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: , MD

29c. License number: D48106

29d. Date signed (Month, Day, Year): June 9th, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI BOAITEY, 301 Hospital Dr., Glen Burnie, MD 21061

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Saul Kushner

30+1

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: Jeanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #7,8&18 PER FH G808 6/20/02 JH

# Certificate of Death

Reg. No. 2002 18661

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Lucille Lorraine Kasulen | June | 6 | 2002 | 9:05 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Longview Nursing Home | Manchester | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-26-7294 | 1☐M 2☒F | 72 ~~82~~ Yrs. | | | March 11 1930 ~~1920~~ | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| PA | Adams | Hanover | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1101 Roosevelt Court | 17331 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Credit Authorizer | Finance |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Henry Schulz | ~~Mae~~ MARY Walters |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Anthony J. Kasulen (Husband) | 1101 Roosevelt Court Hanover, Pennsylvania 17331 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Dulaney Valley Mem. Gdns. | 6/10/2002 | Timonium, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Steven T. Bittle | Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, MD 21212 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Parkinson's Disease — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐~~No~~ 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☐~~No~~ | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☐~~No~~ | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐~~Nursing Home~~ 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐~~Natural~~ 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D33615 | 6/8/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven Slaffer 2111 Hanover Pike Hampstead MD 21074

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | Dennis B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18662

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Kuszmaul, Lawrence 6/5/02 6:40pm

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. Decedent's Name *(First, Middle, Last)*: LAWRENCE KUSZMAUL, JR. | | | | | | | 2. Date of Death: Month June Day 5 Year 2002 | 3. Time of Death: 6:40 PM |
| 4e. Facility Name *(If not institution, give street and number)*: Hospice of Baltimore at Gilchrist Center | | | | 4b. City, Town, or Location of Death: Towson | | | 4c. County of Death: Baltimore County | |
| 5. Social Security Number: 217-16-7703 | 6. Sex: 1 [X] M 2 [ ] F | 7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | | 8. Date of Birth *(Month, Day, Year)*: Apr 8, 1925 | 9. Birthplace *(State or Foreign Country)*: Maryland | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State: Maryland | 10b. County: Baltimore County | 10c. City, Town or Location: Towson | | | | | 10d. Inside City Limits: 1 [ ] Yes 2 [X] No | |
| 10e. Street and Number: 5178 Orchard Green | | 10f. Zip Code: 21045 | | | | 10g. Citizen of What Country?: USA | | |
| 11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 43-46 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 4 yrs | 16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Engineer | | | | 16b. Kind of Business/Industry: Construction | | |
| 17. Father's Name *(First, Middle, Last)*: Lawrence Kuszmaul, Jr. | | 18. Mother's Name *(First, Middle, Maiden Surname)*: Ethel Mae Day | | | | | | |
| 19a. Informant's Name/Relationship *(Type, Print)*: Harriett Turner Kuszmaul (Wife) | | 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5178 Orchard Green, Columbia, Maryland 21045 | | | | | | |
| 20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)* | 20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem Grdns | Date: 6/8/02 | 20c. Location - City or Town, State: Timonium, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee: Martin D. Lawson | | 22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212 | | | | | | |

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

| | | | |
|---|---|---|---|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | a. Prostate Cancer | Due to (or as a consequence of): | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | Due to (or as a consequence of): | |
| | c. | Due to (or as a consequence of): | |
| | d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Hospice

| | | | | |
|---|---|---|---|---|
| 27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | | | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)* |

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed *(Month, Day, Year)* |
|---|---|---|
| W. Anthony Riley, MD | D25205 | June 6, 2002 |

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

| 31. Date filed *(Month, Day, Year)* | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18663

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ATLAS KEENE

2. Dete of Deeth — Month: JUNE Dey: 10 Year: 2002

3. Time of Death: 10AM

4e Fecility Neme *(If not institution, give street end number)*: GENESIS HOMEWOOD

4b. City, Town, or Location of Deeth: BALTIMORE

4c. County of Deeth: N/A

**Funeral Director**

5. Sociel Security Number: 220-20 2523

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. lest birthdey)*: 73 Yrs.

If Under 1 Year — Months: Deys: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: JAN. 9,1929

9. Birthplace *(State or Foreign Country)*: MD.

Usuel Residence of Decedent

10a. Stete: MD.

10b. County: N/A

10c. City, Town or Locetion: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 2245 REISTERSTOWN ROAD

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes [X] No If Yes, Give Year or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify* BLACK

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 10TH College (1-4or 5+):

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DRIVER

16b. Kind of Business/Industry: CONSTRUCTION

17. Fether's Neme *(First, Middle, Last)*: JOHNNIE CEPHAS

18. Mother's Name *(First, Middle, Maiden Sumame)*: ETHEL KEENE

19a. Informant's Name/Relationship *(Type, Print)*: ANNETTE K. KEENE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7159 MC CLEAN BLVD. BALTO,MD. 21234

20a. Method of Disposition: 1 [ ] Burial [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GREEN MOUNT CREMATORY

Date: JUNE 11,2002

20c. Location - City or Town, State: BALTO,MD.

21. Signature of Funeral Service Licensee: Bernadine W. Scruggs

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO,MD. 21213

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

e. Liver mass probably Malignant

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Peritonitis

Due to (or es e consequence of):

c. Pneumonia

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Anemia dehydration

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: PHYSICIAN

29c. License number: D 57543

29d. Date signed *(Month, Dey, Year)*: 6-10-02

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): P. SANDHU, MD 3007E, NORTHERN PKWY, BALTIMORE, MD 21214

**State Registrar**

31. Date filed *(Month, Dey, Year)*: JUN 11 2002

32. Registrer's Signature: Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Merylend Department of Health end Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the death certificete be executed within 24 hours efter deeth.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18664

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Dorothy Helen Karwacki | June 9, 2002 | 2:16 A.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Johns Hopkins Hospital | Baltimore | n/a |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-24-0567 | 1☐ M 2☒ F | 71 Yrs. | | | June 13,1930 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | n/a | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2036 Eastern Avenue | 21231 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Home Maker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frank W. Karwacki | Helen V. Chylinska |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Eugene Karwacki (brother) | 8422 Coco Road Baltimore, Maryland 21237 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Holy Rosary Cemetery | June 12,02 | Baltimore, Md. |

21. Signature of Funeral Service Licensee: ▶ Robert J. Kaczorowski Jr. M00933

22. Name and Address of Facility: Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue Baltimore, Md. 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic prostate cancer | 1 MONTH |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M. Purcell Staff Physician | D19714 | 6/10/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL PURCELL JHBMC 4940 Eastern Ave, Baltimore, Md 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | Bernice D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18665

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| MARGARET | MARY | LOWMAN | JUNE 9, 2002 | 4:45 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| CHESAPEAKE HOSPICE HOUSE | LINTHICUM | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-30-1583 | 1☐ M 2☒ F | 76 Yrs. | | | JAN. 31, 1926 | IRELAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | FERNDALE | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 201 WINTON AVENUE | 21061 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | ELECTRONIC ASSEMBLER | MARTIN MARIETTA |
| 12 | | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOHN COLEMAN | ELIZABETH BRADY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. BONNIE NUGENT (DAUGHTER) | 796 BLENHEIN COURT, SEVERNA PARK, MD. 21146 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | CHESAPEAKE CREMATION CENTER | JUNE 10, 2002 | STEVENSVILLE, MD. |

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Ovarian Cancer | 6.5 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) In Patient Hospice

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Wm C Waterfield MD

29c. License number D24356

29d. Date signed (Month, Day, Year) June 10, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wm C WATERFIELD MD St Agnes Healthcare 900 Caton Ave Baltimore, Md 21229

**State Registrar**

31. Date filed (Month, Day, Year) JUN 11 2002

32. Registrar's Signature ▶ Bonnie B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18666

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| William J. Motschiedler, Jr. | MAY 28 2002 | 9:10 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GREATER BALTIMORE MEDICAL CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-50-6200 | 1 [X] M 2 [ ] F | 53 Yrs. | | | Oct 17, 1948 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Towson | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8419 Loch Raven Blvd | 21286 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Appraiser | Real Estate |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William J. Motschiedler,Sr. | Dorothy Goyert |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Linda Motschiedler/Wife | 8419 Loch Raven Blvd, Towson, MD 21286 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Chesapeake Crematory | Jun 12 2002 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Style D Lehmann M00382 | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. coronary artery disease — 30 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. hyperlipidemia — 30 years

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

hypertensive encephalopathy

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD. | D41104 | 5 29 02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ted Houk MD 7825 York Rd Towson MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | [signature] |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Motschiedler, William J.

PATRICIA MCAVOY
LRB
02-2785-510

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18667

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Patricia Mc Avoy | MAY 28 2002 | 9:27 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Johns Hopkins Bayview | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-56-3828 | 1☐M 2☒F | 49 Yrs. | | | Sep 22, 1952 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 228 Oldham Street | 21224 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Guy Gum | Clara Cynthia McAvoy |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Susan Kenney/Cousin | 8029 Gray Haven Road, Baltimore, MD 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | Jun 14 2002 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Stephen D Lohmann M00382 | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Narcotic intoxication

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☒Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined | 5-28-02 | Unk. M | 1☐Yes 2☒No | Unknown |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| House | 228 Oldham St.,Baltimore,MD |

29a. Certifier (Check only one) 1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | O.C.M.E. | MAY 29, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. LAWRENCE LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18668

**Physician /Medical Examiner**

1. Decedent's Nama *(First, Middla, Last)*: Margaret Doris Muldowney

2. Data of Daath — Month: June; Day: 10; Yaar: 2002

3. Tima of Death: 1510

4a Facility Nama *(If not institution, giva street and number)*: Augsburg Lutheran Home

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Death: Baltimore

**Funeral Director**

5. Social Sacurity Numbar: 214-20-5056

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 76 Yrs.

If Undar 1 Year — Months: ; Days:

If Undar 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Yaar)*: Apr 9, 1926

9. Birthplaca *(Stata or Foraign Country)*: MD

Usual Rasidance of Dacedent

10a. Stata: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 4300 Cardwell Avenue

10f. Zip Coda: 21236

10g. Citizan of What Country?: United States

11. Maritel Status: 1☐ Navar Marriad 2☐ Married 3☐ Widowad 4☒ Divorced

12. Was Dacadant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Spacify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, etc. *Spacify:* White

15. Decedant's Education *(Specify only highast grada completad)*: Elementary/Sacondary (0-12): 12; Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Nama *(First, Middla, Last)*: Thomas McCord

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Mary Agnes Shepherd

19a. Informant's Name/Relationship *(Type, Print)*: Christine Muldowney/Daughter

19b. Mailing Address *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Code)*: 2715 Woodside Avenue, Baltimore, MD 21211

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Date: Jun 13 2002

20c. Location - City or Town, Stata: Beltsville, MD

21. Signature of Funeral Service Licensee: Studie D Lohmann MA0382

22. Nama and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

**Physician /Medical Examiner**

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach line.

Approximata Interval Batwaan Onsat and Daath

Immediate Cause (Final disaasa or condition resulting in daath)
a. Right lower extremity gangrene — 2 weeks

Due to (or as a consaquanca of):
b. PVD — years

Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last
Due to (or as e consaquanca of):
c. IDDM — years

Due to (or as a consaquance of):
d.

Part II. **Other significant conditiona** contributing to daath but not resulting in tha undarlying causa givan in Part I.

23b. Did tobacco usa contributa to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy parformad? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not ba datarminad

28a. Date of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha bast of my knowledge, daath occurrad at tha time, data and place, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and placa, and dua to tha causa(s) and manner stated.

29b. Signature end title of certifier

29c. Licansa numbar: D37573

29d. Data signad *(Month, Day, Yaar)*: June 10, 2002

30. Nama and addrass of person who completed cause of daath (Item 23a) (Type, Print): Jef Zibell MD 25 Main St. Reisterstown MD 21136

**State Registrar**

31. Deta filed *(Month, Day, Yaar)*: JUN 11 2002

32. Registrar's Signatura: Donna P Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Amend Item#5 perINFG808 6/21/02 EW

Reg. No. 2002 18669

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Delmar Wayne Maddox

2. Date of Death: Month June Day 7 Year 2002

3. Time of Death: 3:05pm

4a. Facility Name (If not institution, give street and number): Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 329-05-5697 (~~6347~~)

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 20 1920

9. Birthplace (State or Foreign Country): Illenois

**To Be Completed by Funeral Director**

Usual Residence of Decedant

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Insida City Limits: 1 ☐ Yas 2 ☒ No

10e. Street and Number: 27 Sugar Tree Place

10f. Zip Code: 21030

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self employed

16b. Kind of Business/Industry: Steel

17. Father's Name (First, Middle, Last): Everett Maddox

18. Mother's Name (First, Middle, Maiden Surname): Bertha Nickels

19a. Informant's Name/Relationship (Type, Print): Beatrice Maddox

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27 Sugar Tree Place Cockeysville, Md 21030

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Evans Funeral Chapel - Balto. | Date: June 10 2002

20c. Location - City or Town, State: Forest Hill, Md

21. Signature of Funeral Service Licensee: Keith S Wells

22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. congestive heart failure — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Helen M Garda

29c. License number: D0051926

29d. Date signed (Month, Day, Year): June 10, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M. Garda 6565 N. Charles St, Baltimore MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: Jennifer D. Sparks

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

6-7-02 3:05pm Delmar Maddox

RL 15

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18670

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Dorothy McGriff | June 9, 2002 | 10:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1417 Bayview Drive | Havre de Grace | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-44-4436 | 1☐M 2☒F | 91 Yrs. | | | OCT 6, 1910 | Alabama |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Havre de Grace | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1417 Bayview Drive | 21078 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No 1942-1945 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5 | Social Worker | V.A. Hospital |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Marcus McGriff I | Luda Mae Ingram |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Marcus McGriff/Nephew | 29 Hickory Hollow S.W. Cartersville, GA 30120 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Crematory Inc. | 6-11-02 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Thomas Gregor | Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. History of cerebrovascular accident

Due to (or as a consequence of):

c. Osteoarthritis

Due to (or as a consequence of):

d. Hypertension.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Hi Sup Sim MD | D4642 | June 10, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
3/9 S. Union Ave Hbg MD 21078 Hi Sup Sim.

8

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | Donna B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item#26 perVERBALG809 7/1/02 EW

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18671

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edward Owen Merryman
2. Date of Death: Month June, Day 8, Year 2002
3. Time of Death: 9:05 A M
4a. Facility Name (If not institution, give street and number): 63 Penny Lane
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 579-12-0825
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): March 10, 1921
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 Yes 2 X No
10e. Street and Number: 806 8th Street Apt 104
10f. Zip Code: 20707
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): George Frederick Merryman
18. Mother's Name (First, Middle, Maiden Surname): Nellie Tucker

19a. Informant's Name/Relationship (Type, Print): Thomas Merryman Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 63 Penny Lane Baltimore, Maryland 21209

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery
Date: 6/12/02
20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: Stephen M. Jenki
22. Name and Address of Facility: Eline Funeral Home 21136
11824 Reisterstown Road Reisterstown, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. A.S.C.V.D — Approximate Interval Between Onset and Death: > 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Ventricular arrhythmias — > 1 year
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 ~~No~~
26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Son's residence ~~Home~~

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 X No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D42736
29d. Date signed (Month, Day, Year): 6-10-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ayman Akkad 3600 Osler Dr. #411 Towson MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18672

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ELIZABETH A. McMAHON

2. Date of Death Month Day Year: JUNE 9, 2002

3. Time of Death: 1:30 a.m.

4a. Facility Name *(If not institution, give street and number)*: 3706 FOSTER AVENUE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-30-5136

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)* Yrs.: 85

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN. 15, 1917

9. Birthplace *(State or Foreign Country)*: MARYLAND

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3706 FOSTER AVENUE

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: WAITRESS

16b. Kind of Business/Industry: RESTAURANT

17. Father's Name *(First, Middle, Last)*: CHARLES ECKHARDT

18. Mother's Name *(First, Middle, Maiden Surname)*: BARBARA HOFFMAN

19a. Informant's Name/Relationship *(Type, Print)*: GEORGETTE MEYERS/ DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 912 S. BOULDIN STREET, BALTIMORE, MD. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: OAK LAWN CEMETERY

Date: 6/12/02

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MD. 21224

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Pancreatic Cancer

Due to (or as a consequence of): b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HTN, CAD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D42908

29d. Date signed *(Month, Day, Year)*: 6/10/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Schardt, MD 508 S. Conkling St. Balt. MD 21224

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**State Registrar**

31. Date filed *(Month, Day, Year)*: JUN 11 2002

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18673

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): STANLEY ANTHONY MRAZECK, SR.
2. Date of Death (Month, Day, Year): JUNE 5, 2002
3. Time of Death: 1:25 P M
4a. Facility Name (If not institution, give street and number): 7831 BROCKBRIDGE ROAD
4b. City, Town, or Location of Death: JESSUP
4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 163-22-5841
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6/5/1927
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2 XX No
10e. Street and Number: 1620 SUNSHINE STREET
10f. Zip Code: 21061
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3 XX Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No — If Yes, Give Year or Dates: 1945-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ENGINEER
16b. Kind of Business/Industry: BGE

17. Father's Name (First, Middle, Last): JOHN MRAZECK
18. Mother's Name (First, Middle, Maiden Surname): MARY

19a. Informant's Name/Relationship (Type, Print): STANLEY A. MRAZECK, JR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 807 PARADISE LANE, GLEN BURNIE MD 21061

20a. Method of Disposition: XX 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HOLLY HILLS CEM.
Date: 6/8/2002
20c. Location - City or Town, State: MIDDLERIVER, MD

21. Signature of Funeral Service Licensee: KELLY GREGORY FINK #MO1148
22. Name and Address of Facility: FINK FUNERAL HOME, PA — 426 CRAIN HWY S, GLEN BURNIE, MD 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes XX No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2 XX No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6 XX Other (Specify) RESIDENCE OF CAREGIVER

27. Manner of Death: 1 X Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Peter Ramzy MD
29c. License number: D47137
29d. Date signed (Month, Day, Year): June, 6, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PETER P RAMZY MD 7845 Oakwood rd Suite 201 Glen Burnie md 21061

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: Deputy B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18674

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DONALD P. MAYHUE
2. Date of Death (Month, Day, Year): JUNE 7, 2002
3. Time of Death: 12:15 AM
4e. Facility Name (If not institution, give street and number): HERITAGE NURSING HOME
4b. City, Town, or Location of Death: DUNDALK
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 200-07-8239
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/22/13
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: DUNDALK
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street end Number: 7536 RABON AVE.
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Maritel Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: NATIONAL CAN

17. Father's Name (First, Middle, Last): PARLEY MAYHUE
18. Mother's Name (First, Middle, Maiden Surname): MARYANN PRICE

19a. Informant's Name/Relationship (Type, Print): MRS. ELEANOR SPIEDT
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6728 BOSTON AVE. BALTO., MD. 21222

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OAK LAWN CEMETERY
Date: 6/10/02
20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: ▶ [signature]
22a. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD.21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Atherosclerotic Cardiovascular Disease — 5 years
Due to (or as a consequence of):
b. Senile dementia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobecco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D30641
29d. Date signed (Month, Day, Year): June 7 2002

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Ramesh Sabapathi 201-109 Backriver Neck Road Baltimore MD 21221

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrer's Signature: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18675

melvin milner

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MELVIN B. MILNER
2. Date of Death: Month June Day 6 Year 2002
3. Time of Death: 2311 PM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 220-18-3888
6. Sex: 1 ☐ M 2 ☐ F — X
7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 1 1927
9. Birthplace (State or Foreign Country): MD.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6709 MAURLEEN ROAD
10f. Zip Code: 21209
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNER
16b. Kind of Business/Industry: WHOLESALE MERCHANDISE

17. Father's Name (First, Middle, Last): DAVID MARTIN MILNER
18. Mother's Name (First, Middle, Maiden Surname): MARY LAVER

19a. Informant's Name/Relationship (Type, Print): MRS. ETHEL MILNER/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6709 MAURLEEN ROAD PIKESVILLE, MD. 21209

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): B'NAI ISRAEL CONG-MISHKON ISRAEL SECTION
Date: 6/9/02
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease — 4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Renal Insufficiency — 4 years
c. Due to (or as a consequence of): Diabetes Mellitus — 4 years
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D15871
29d. Date signed (Month, Day, Year): 6/7/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LAWRENCE BOAS MD 54 SCOTT ADAM Rd Cockeysville Md 21030

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: [signature]

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18676

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LOUIS E. NOVAK

2. Date of Death: Month JUNE Day 7, Year 2002

3. Time of Death: 3:25 P M

4a. Facility Name (If not institution, give street and number): SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 220-20-2961

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 1/2/28

9. Birthplace (State or Foreign Country): MARYLAND

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: PARKVILLE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8800 WALTHER BLVD. APT. 1613

10f. Zip Code: 21234

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10th GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BRANCH CHIEF

16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Father's Name (First, Middle, Last): EDWARD NOVAK

18. Mother's Name (First, Middle, Maiden Surname): PAULINE SHRZANOWSKI

19a. Informant's Name/Relationship (Type, Print): CARMELA A. NOVAK/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8800 WALTHER BLVD. APT.1613 BALTO., MD 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): DULANEY VALLEY MEM GAR. Date: 6/11/02

20c. Location - City or Town, State: COCKEYSVILLE, MD

21. Signature of Funeral Service Licensee: Heather N. Hayes

22. Name and Address of Facility: JOHNSON FUNERAL HOME P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE RENAL DISEASE — 2 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SEPTICEMIA — 10 DAYS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

TYPE II DIABETES MELLITUS

SEVERE PERIPHERAL VASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Natividad D. de Leon, M.D.

29c. License number: D19508

29d. Date signed (Month, Day, Year): 7th June 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NATIVIDAD D. DE LEON, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: Bonnie B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other then "natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2002 18677

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ernest L. Phillips

2. Date of Death: Month JUNE Day 4, Year 2002

3. Time of Death: 5:40 P M

4a. Facility Name *(If not institution, give street and number)*: 1212 Carroll Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-32-4948

6. Sex: 1☑ M 2☐ F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEP. 9, 1935

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☐ No X

10e. Street and Number: 1212 Carroll Street

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: White Coffee Pot

17. Father's Name *(First, Middle, Last)*: Ernest L. Phillips, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Thelma Sullivan

19a. Informant's Name/Relationship *(Type, Print)*: Sharon Phillips - daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1212 Carroll Street, Baltimore, Md. 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lorraine Park Cem.

Date: 6/11/02

20c. Location - City or Town, State: Baltimore, MD.

21. Signature of Funeral Service Licensee: ▶ Heather A. Brown

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiomyopathy — 4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Christopher Lang MD

29c. License number: D32263

29d. Date signed *(Month, Dey, Year)*: 6/10/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1940 West Baltimore St Baltimore 21223

**State Registrar**

31. Date filed *(Month, Day, Yeer)*: JUN 11 2002

32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18678

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOSEPH A. PERNA
2. Date of Death (Month, Day, Year): JUN 05 2002
3. Time of Death: 11:30P M
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

**Funeral Director**

5. Social Security Number: 164-28-0279
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 5, 1936
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 4900 Ilchester Road
10f. Zip Code: 21043
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Self-employed Business

17. Father's Name (First, Middle, Last): Joseph Perna
18. Mother's Name (First, Middle, Maiden Surname): Pasqualena R. Paluso

19a. Informant's Name/Relationship (Type, Print): Tom Perna - son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4900 Ilchester Road, Ellicott City, Md. 21043

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Pk.
Date: 6/10/02
20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: ▶ Heather A. Brown
22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 20175

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NON SMALL CELL LUNG CARCINOMA — 8 MONTHS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause ot death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D0018317
29d. Date signed (Month, Day, Year): JUN 05 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BERNARD P. FARRELL MD
11055 LITTLE PATUXENT PARKWAY, COLUMBIA, MD 21044

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: Sandra G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18679

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Beulah M. Pickett | June 6 2002 | 4:15 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Franklin Square Hospital | Rosedale | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 239-32-2160 | 1 ☐ M 2 ☒ F | 74 Yrs. | | | January 15, 1928 | North Carolina |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Rosedale | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6600 Ridge Road | 21237 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Custodian | Baltimore County Schools |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Gilbert | Unknown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Bercha Owens/Daughter | 1630 Gail Road Apt.4 Baltimore, MD 21221 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Pickett Cemetery | 6/11/2002 | Duplin, North Carolina |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ R. Terry Connelly | Connelly Funeral Home Of Essex 300 Mace Avenue, Baltimore, Maryland 21221 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Intracerebral hemorrhage | 1 DAY |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | 53547 | 6/6/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sanjay Jagannath 9000 Franklin Square Dr. Baltimore Md. 21237

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#20b,20c perFHG808 6/26/02 EW

# Certificate of Death

Reg. No. 2002 18680

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROGER L. PRYOR
2. Date of Death Month/Day/Year: JUNE 2 2002
3. Time of Death: 4:05A M
4a. Facility Name (If not institution, give street and number): Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore MD
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 217-66-8463
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 46 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): JUNE 25, 1955
9. Birthplece (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5029 BALTIMORE NATIONAL PIKE
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. AFRICAN Specify: AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): AUDIO-VIDEO TECHNICIAN
16b. Kind of Business/Industry: LIBRARY

17. Father's Name (First, Middle, Last): ENNIS PRYOR
18. Mother's Name (First, Middle, Maiden Surname): SADIE DAVIS

19a. Informant's Name/Relationship (Type, Print): DOLLY PRYOR (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 115 W. HENRIETTE STREET BALTIMORE, MD 21221

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Family Cemetery ~~MT. ZION CEMETERY~~
Date: 6/17/02 ~~6/12/02~~
20c. Location - City or Town, State: Randallstown, Md ~~LANSDOWNE, MD~~

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pseudomonas Sepsis
Due to (or as a consequence of):
b. Indwelling catheter
Due to (or as a consequence of):
c. End Stage Renal Disease
Due to (or as a consequence of):
d. Hepatitis C cirrhosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hepatocellular Carcinoma

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: P15832
29d. Date signed (Month, Dey, Year): 6/8/2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Thomsen 157 Bayden Rd. Baltimore, MD 21212

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18681

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mae Birt Perry

2. Date of Death — Month: JUNE Day: 09 Year: 2002

3. Time of Death: 5:30 PM

4a. Facility Name (If not institution, give street end number): St. AGNES HEALTH CARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 238-26-7911

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 3, 1922

9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 241 S. Hilton St.

10f. Zip Code: 21229

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed) — Elementery/Secondary (0-12): 11th — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nursing Aide

16b. Kind of Business/Industry: Nursing Home

17. Father's Name (First, Middle, Lest): Jimmie Rose

18. Mother's Name (First, Middle, Maiden Surname): Nora Hines

19a. Informant's Name/Relationship (Type, Print): Robert L. Perry - husband

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 241 S. Hilton St. Balto., MD 21229

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park

Date: 6-14-02

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Gary P. March

22. Name and Address of Facility: Gary P March Funeral Home P.A. 2710 Fred Hilton Pass Balto, MD 21229

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — DAYS

Due to (or as a consequence of):

b. SARCOIDOSIS — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobecco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☒ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier: MD

29c. License number: 15626

29d. Date signed (Month, Day, Year): JUNE ; 09 ; 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TUN NYUNT, St. AGNES HEALTH CARE 900 CATON AVE, BALTIMORE, MD 21229

**To the Hospital or Attending Physician:** The law requires thet the death certificete be excuted within 24 hou s after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for usa es the burial-transit

NAME Perry, Mae

RR

RR 4

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18682

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Robert Glenn Rhodes | June 10, 2002 | 8:15 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Stella Maris Hospice | Timonium | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 210-18-9698 | 1 [X] M 2 [ ] F | 75 Yrs. | | | April 16, 1927 | PA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Timonium | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 20 Hathaway Road | 21093 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 45'-46' | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Store Manager | Automotive |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George W. Rhodes | Naomi Snively |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| G. Elaine Rhodes/Wife | 20 Hathaway Road Timonium, MD 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Baltimore Washington Crematory | June 11, 2002 | Laurel, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Michael J. Flagle | Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. LUNG CANCER | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) HOSPICE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D43725 | 6/10/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

JUNE 10, 2002 8:15 a.m.

Division of Vital Records, P.O. Box 68760, **To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ROBERT RHODES

12-1

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#5 perFHG808 6/25/02 EW AMEND ITEM #30 PER DVR G808 6/11/02 JH

# Certificate of Death

Reg. No. 2002 18683

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| SELMA | | RANDALL | JUNE | 8 | 2002 | 6:50 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| RUXTON-PIKESVILLE NURSING HOME | PIKESVILLE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 212-12-~~6207~~ 6702 | 1 ☐ M 2 XX F | 90 Yrs. | | | | | AUG.22,1911 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1 ☐ Yes 2 XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3724 PARKFIELD ROAD | 21208 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced | 1 ☐ Yes XX No If Yes, Give Year or Dates: | 1 ☐ Yes XX No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | SALESPERSON | RETAIL |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| JOSEPH | GOLDMAN | REBECCA | COHEN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CHARLES RANDALL / SON | 3724 PARKFIELD ROAD - BALTIMORE, MD 21208 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| X 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | MOSES MONTEFIORE | 6/9/2002 | BALTIMORE, MD. |

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | HYPOXIA | acute |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a consequence of): Carcinoma of the Lung | 2 years |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic cardiovascular disease

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Herbert General Ostr | D-16060 | 6.8.02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HERBERT G. OSTER 3635 OLD COURT RD. PIKESVILLE,MD. 21208

**State Registrar**

| 31. Date filed (Month, Day, Yeer) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18684

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Eureth Schwemmer | June | 3 | 2002 | 12:30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 5690 Chambliss Drive | Clarksville | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-10-8823 | 1☐M 2☒F | 81 Yrs. | | | Mar 22 1921 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Howard | Clarksville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5690 Chambliss Drive | 21029 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Cashier | Food Service |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Isaac Stewart | Augusta Mae Goodwin |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dorothea Smith / Daughter | 5690 Chambliss Drive, Clarksville, Maryland 21029 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Meadowridge Mem. Park | 6/6/2002 | Elkridge, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: Months

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D22856 | June 4, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerry I. Levine, DO, 11055 Little Patuxent Pky Columbia, Md 21044

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18685

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Viola Sappe | JUNE6, 2002 | 4:13 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1306 SOUTH HANOVER STREET | BALTIMORE | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| unknown | 1☐ M 2☒ F | 78 Yrs. | | | Feb 14, 1924 | AR |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1306 South Hanover Street | 21230 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Waitress | Hospitality |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Unknown Crosswhite | Unknown Unknown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Michael Chearney/Son | 700 Clara Terr., Bel Air, MD 21014 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Chesapeake Crematory | Jun 12 2002 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Stephen D. Lohmann MD038 | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Arteriosclerotic Cardiovascular Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Theodore McKeiver MD | O.C.M.E | JUNE 7, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE McKEIVER 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | ▶ Brenda D Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18686

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gloria Elaine Spellman.

2. Date of Death (Month, Day, Year): June 10 2002

3. Time of Death: 7.50 A M

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-20-2854

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2/4/24

9. Birthplace (State or Foreign Country): Maryland.

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8313 Overmont Ave.

10f. Zip Code: 21234

10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White.

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12.

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: athome

17. Father's Name (First, Middle, Last): John L. Lentz

18. Mother's Name (First, Middle, Maiden Surname): Hilda L. Moebis

19a. Informant's Name/Relationship (Type, Print): Oswald Spellman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8313 Overmont Rd., Parkville MD 21234.

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem Gar. Date: 6/13/02

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Krista S. Wells

22. Name and Address of Facility: BALTIMORE, MD 21234 EVANS FUNERAL CHAPEL, 8800 HARFORD RD.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock — 10 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ovarian Cancer — 3 months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 28717

29d. Date signed (Month, Day, Year): June 10 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Stephen Selinger 9000 Franklin Square Drive Baltimore, MD. 21237

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: [signature] D. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg No. 2002 18687

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARIANNE STEWART
2. Date of Death: Month JUNE Day 9 Year 2002
3. Time of Death: 1849
4a. Facility Name (If not institution, give street end number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

**Funeral Director**

5. Social Security Number: 131-32-1515
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 10, 1941
9. Birthplace (State or Foreign Country): NEW JERSEY

Usual Residence of Decedent

10a. State: Maryland
10b. County: HARFORD
10c. City, Town or Location: BEL AIR
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 706 LAGNEY COURT
10f. Zip Code: 21014
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 YRS. College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: AT HOME

17. Father's Neme (First, Middle, Lest): MARTIN FLESSHUT
18. Mother's Name (First, Middle, Maiden Surname): ANNA ZIMMERMAN

19a. Informant's Name/Relationship (Type, Print): PETER A. STEWART
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 706 LAGNEY COURT BEL AIR, MARYLAND 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BEL AIR MEM. GARDENS
Date: JUN 13 2002
20c. Location - City or Town, State: BEL AIR MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EVANS FUNERAL CHAPEL — BEL AIR, P.A. 21050 3 NEWPORT DRIVE FOREST HILL MARYLAND

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
e. ADULT Respiratory Distress Syndrome — 2 days
Due to (or as a consequence of):
b. PULMONARY EDEMA — 3 days
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c. Failed HEART TRANSPLANT — 1 Week
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD/PhD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): June 10 2002

30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print): Gregory A. Hosler MD/PhD; 600 N. Wolfe St. Baltimore, MD 21287

**State Registrar**

31. Dete filed (Month, Day, Year): JUN 11 2002
32. Registrer's Signeture: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours efter death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

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DHMH 16 Rev 6/95

ORIGINAL

02-3054-510
B.K.S
UNKNOWN 02-176
TANYA ANN JONES - SPENCE

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18688

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): TAWNIA A. JONES - SPENCE

2. Date of Death (Month, Day, Year): JUNE 7, 2002

3. Time of Death: 2043 PM

4a. Facility Name (If not institution, give street and number): UNIVERSITY HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 220-86-5954

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 29 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 16, 1972

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: RANDALLSTOWN

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8618 BRAMBLE COURT

10f. Zip Code: 21133

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FOOD SERVICE

16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): RICKY JONES

18. Mother's Name (First, Middle, Maiden Surname): MARJORIE JONES

19a. Informant's Name/Relationship (Type, Print): KATRINA JONES (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 915 MONROE STREET BALTIMORE, MARYLAND 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY

Date: 6/15/02

20c. Location - City or Town, State: LANSDOWNE, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gunshot Wounds OF Torso

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☒ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 6/7/02

28b. Time of Injury: 4:55 PM

28c. Injury at Work? 1☐ Yes 2☑ No

28d. Describe how injury occurred: Subject Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Apartment Building

28f. Location (Street and Number or Rural Route Number, City or Town, State): 8618 Bramble Lane Randlestown, Maryland

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] J. Pestaner, M.D.

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): JUNE 8, 2002

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18689

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Karin R. Smith
2. Date of Death — Month: June; Day: 10; Year: 2002
3. Time of Death: 12:58 PM
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 220-78-1387
6. Sex: 1☐M 2☑F
7. Age (In yrs. last birthday): 45 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 22, 1957
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 5421 Radecke Ave.
10f. Zip Code: 21206
10g. Citizen of What Country: USA

11. Marital Status: 1☑Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: Bank

17. Father's Name (First, Middle, Last): Eddie W. Smith
18. Mother's Name (First, Middle, Maiden Surname): Bernice Fowler

19a. Informant's Name/Relationship (Type, Print): Bernice Fowler Smith - mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4822 Hamilton Ave. Balto., MD 21206

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 6-15-02
20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service License
22. Name and Address of Facility: Gary P. March Funeral Home P.A. 240 Fredhilton Pass Balto. MD 21229

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 6 months

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Colon Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery — Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: AT 243946
29d. Date signed (Month, Day, Year): June 10 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Omar Dorzi 201 E University Parkway, Baltimore, MD 21218

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18690

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William W. Schneider
2. Date of Death (Month, Day, Year): June 10, 2002
3. Time of Death: 6:30 AM M
4a. Facility Name (If not institution, give street and number): 8243 Poplar Mill Road
4b. City, Town, or Location of Death: White Marsh
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 096-03-2527
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR 26, 1913
9. Birthplace (State or Foreign Country): New York

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: White Marsh
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8243 Poplar Mill Road
10f. Zip Code: 21236
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Gulf Oil Company

17. Father's Name (First, Middle, Last): Henry Schneider
18. Mother's Name (First, Middle, Maiden Surname): Anna Bressler

19a. Informant's Name/Relationship (Type, Print): Emily Schneider/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8243 Poplar Mill Road White Marsh, MD 21236

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 6-11-02
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. lung cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
emphysema

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Samuel Dunso MD
29c. License number: D47040
29d. Date signed (Month, Day, Year): June 10, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Samuel Dunso MD, 4924 Campbell Blvd. Baltimore, MD 21236

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18691

**Physician /Medical Examiner** | **Funeral Director**

1. Decedent's Name (First, Middle, Last): NANCY SMITHSON
2. Date of Death (Month, Dey, Year): JUNE 8 2002
3. Time of Death: 12:29 pm
4a. Facility Name (If not institution, give street end number): MERCY MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE
5. Social Security Number: 217-50-6525
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): DEC 27, 1948
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1110 Carroll Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress
16b. Kind of Business/Industry: Restaurant

17. Father's Neme (First, Middle, Last): Raymond Fincham
18. Mother's Name (First, Middle, Maiden Surname): Betty Gonsalez

19a. Informant's Name/Relationship (Type, Print): Scott W. Clayton/Son
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 630 S. Linwood Street Baltimore, MD 21224

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 6-10-02
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset end Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. SEPSIS | 3 days |
| Due to (or es e consequence of): | b. CLOSTRIDIUM DIFFICILE COLITIS | UNKNOWN |
| Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. STREP SALIVARIUS BACTEREMIA | UNKNOWN |
| Due to (or as e consequence of): | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier:
29c. License number: D5036
29d. Date signed (Month, Day, Year): JUNE 8, 2002

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): JOHN T BONACUM 30 ST PAUL PL, BALTIMORE, MD 21202

**State Registrar**

31. Date filed (Month, Dey, Year): JUN 11 2002
32. Registrer's Signeture:

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that tha death certificate be executed within 24 hours efter death.
**To the Funeral Director:** After this cartificata has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18692

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Donald G Stallings
2. Date of Death: Month June Day 6 Year 2002
3. Time of Death: 12:40 A M
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 216-03-7096
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 25, 1912
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 Yes 2 X No
10e. Street and Number: 5118 Durham Road East
10f. Zip Code: 21044
10g. Citizen of What Country?: USA
11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed/Owner
16b. Kind of Business/Industry: Tavern/Restaurant
17. Father's Name (First, Middle, Last): John Leo Stallings
18. Mother's Name (First, Middle, Maiden Surname): Sarah Tarleton
19a. Informant's Name/Relationship (Type, Print): Naomi J. Stallings/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5118 Durham Road East, Columbia, MD 21044
20a. Method of Disposition: 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 6-7-02
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Septic Shock — 1 day

Due to (or as a consequence of):
b. Pneumonia — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Respiratory Failure, Myelodysplastic Syndrome Anemia, Pancytopenia.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown
24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D46120
29d. Date signed (Month, Day, Year): June 6 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): F Delcan 10714 Little Patuxent Pkwy Columbia, MD 21044

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: Barbara G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18693

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Isabella Smith
2. Date of Death — Month: 6 Day: 10 Year: 02
3. Time of Death: 4 Am

4e. Facility Name *(If not institution, give street and number)*: Worthington Assisted Living
4b. City, Town, or Location of Death: Reisterstown
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212-10-6805
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs.
If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:
8. Date of Birth *(Month, Day, Year)*: Sept. 8, 1915
9. Birthplace *(State or Foreign Country)*: Baltimore, MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 332 Timber Grove Road
10f. Zip Code: 21136
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 2 College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Patrick Tully
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Bradley

19a. Informant's Name/Relationship *(Type, Print)*: Jo-Anne S. Christensen Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 332 Timber Grove Road, Reisterstown, MD 21136

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Carroll Cremations, Inc.
Date: 6/11/02
20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: Jeff S Eline
22. Name and Address of Facility: 11824 Reisterstown Rd. ELINE FUNERAL HOME Reisterstown MD 21136

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cardiovascular collapse
Due to (or as a consequence of):
b. respiratory failure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Becker MD
29c. License number: 23615
29d. Date signed *(Month, Day, Year)*: 6/10/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Becker MD 15 Walker Ave Balto MD 21208

**State Registrar**

31. Date filed *(Month, Day, Year)*: JUN 11 2002
32. Registrar's Signature: Denise D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18694

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| MOLLY | RUTH | STRAUSS | JUNE 6, 2002 | 1:20 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| LEVINDALE HEBREW HOME | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-14-5775 | 1☐M 2☒F | 80 Yrs. | | | MAY 5,1922 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6503 PARK HEIGHTS AVENUE #3-C | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| ISAAC | CAPLAN | IDA | PELOVITZ |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| NEIL STRAUSS / SON | 1874 EAST 26TH STREET - BROOKLYN, NY 11229 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify) | ERETZ HACHAIM CEM. | 6/7/2002 | BEIT SHEMESH, ISRAEL |

21. Signature of Funeral Service Licensee ▶ Michael Krugen

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC ENDOMETRIAL CANCER | MONTHS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEEP VENUS THROMBOSIS, HYPOTHYROIDISM, ANEMIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D33943 | 6/6/2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN M. LEVY, M.D. LEVINDALE 2434 W. BELVEDERE AVENUE 21215

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | ▶ James D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18695

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Morton Sullivan Jr.
2. Date of Death (Month, Day, Year): June 7, 2002
3. Time of Death: 5:30 P M
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-32-0090
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 29, 1935
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3800 W. Belvedere Ave. Apt. 322
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Custodial

17. Father's Name (First, Middle, Last): Morton Sullivan Sr.
18. Mother's Name (First, Middle, Maiden Surname): Ella Robinson

19a. Informant's Name/Relationship (Type, Print): Ms. Bessie Mathews (Friend)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3800 Belvedere Ave. Apt. 322 Balto. Md. 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 6/14/2002
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Aspiration Pneumonia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Chukwuma Ebo
29c. License number: 89455
29d. Date signed (Month, Day, Year): June 7, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chukwuma Ebo MD, c/o Maryland General Hospital

**State Registrar**

31. Date filed (Month, Day, Year): JUN 1 1 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

MORTON SULLIVAN
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

02-3068-510
JERALD THORNTON
RKD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#1 per ME G808 061802 ss
AMEND/UNPEND 061702:ITEMS#20b per fn; #23a,27 per ME G808 sss

# Certificate of Death

Reg. No. 2002 18696

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| ~~Gerald Thornton~~ GERALD ~~THORNTON~~ | JUNE 9, 2002 | 12:45A. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1233 N. CENTRAL AVE | BALTIMORE | N.A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219 38 5912 | 1 X M 2 ☐ F | 63 Yrs. | | | 8/9/38 | Md |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md | N. A | Balto | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1233 N. CENTRAL AVE | 21202 | U.S.A |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: Black. |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Cutter | STANDARD Supply Co |
| 12th | | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Ustey Thornton | Elizabeth Whiting |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Romaine C. Thornton | 1233 N. Central Ave Balto. Md 21202 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | King Mem Pk. | 6-14-02 | 8310 Dogwood Rd |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Joseph G. Locke, Jr | Joseph G. Locke & S/H 1304 N. Central Ave |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 9 ☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) SCENE

27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | O.C.M.E. | JUNE 9, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM#5 per fh G808 062502 ss

2002 18697 Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| William | C. | Verhoven | June | 8, | 2002 | 5:18 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Brightwood Center | Lutherville | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| ~~116-05-5909~~ 116-05-5905 | 1 [X] M 2 [ ] F | 88 Yrs. | | | Nov 3, 1913 | New Jersey |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Severn | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7867 Hickory Leaf Road | 21144 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | n/a | Foreman - Press Operations | Newspaper |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Verhoven | Marie Kemp |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Matilda Verhoven/Wife | 7867 Hickory Leaf Road, Severn, Maryland 21144 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Baltimore-Washington Crematory | 6/10/02 | Laurel, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Bryan W. Clary | Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ASCVD | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | 044804 | June 10, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Karen Dodge, M.D. 828 Ritchie Highway Pasadena, MD 21122

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18698

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| THERESA T. VANLILL | June 8th, 2002 | 8:10 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| North Arundel Hospital | Glen Burnie | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 166-16-5019 | 1 ☐ M 2 ☒ F XX | 85 Yrs. | | | 2/25/1917 | PA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | ANNE ARUNDEL | GLEN BURNIE | 1 ☐ Yes 2 ☒ No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1618 SUNSHINE STREET | 21061 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed XX 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No XX If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No XX Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| UNKNOWN | UNKNOWN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ANNA VANLILL | 1618 SUNSHINE STREET GLEN BURNIE MD 21061 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial XX 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | GLEN HAVEN | 6/10/02 | GLEN BURNIE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ KELLY GREGORY FINK | FINK FUNERAL HOME, PA 426 CRAIN HWY, S GLEN BURNIE, MD 21061 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D48006 | June 8th, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KOFI BOATENG, 301 Hospital Dr., Glen Burnie, MD 21061

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | Donna B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18699

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Walter R. Watkins, Sr.

2. Date of Death: Month 06 Day 05 Year 2002

3. Time of Death: 5:15 A M

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 220-24-7022

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 17, 1930

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2714 Norfen Road

10f. Zip Code: 21227

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman

16b. Kind of Business/Industry: BG&E

17. Father's Name (First, Middle, Last): Walter R. Watkins, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ethel Irene Smith

19a. Informant's Name/Relationship (Type, Print): Mary Ann Watkins - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2714 Norfen Rd., Baltimore, Md. 21227

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Pk.

Date: 6/08/02

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: Heather A. Braun

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural', or Items 23a or 28e-I show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aortic Dissection — 1 Day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Mycotic aneurysm — 12 months

Due to (or as a consequence of):

c. Arteriosclerosis — 20 yrs

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD

29c. License number: AT 243946

29d. Date signed (Month, Day, Year): 06/05/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Trang D. Nguyen — UMMH - 22 S. University Park Way, Baltimore, MD 21218

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: [signature] D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

02-2983-510
PAMELA WALTEMEYER
RKD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061202:items#23a,27,28a-f per ME 0808 ss

# Certificate of Death

Reg. No. 2002 18700

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): PAMELA WALTEMEYER
2. Date of Death: Month JUNE Day 5, Year 2002
3. Time of Death: 7:40P. M
4a. Facility Name (If not institution, give street and number): UNIVERSITY HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: 218-06-1301
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 32 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09/15/1969
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 1180 Nanticoke Street
10f. Zip Code: 21230
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Medical Secretary
16b. Kind of Business/Industry: Healthcare

17. Father's Name (First, Middle, Last): Robert Waltemeyer
18. Mother's Name (First, Middle, Maiden Surname): Katherine McConville

19a. Informant's Name/Relationship (Type, Print): Katherine McConville / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 D Fallen Tree Court, Relay, Maryland 21227

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 06/10/2002
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber
22. Name and Address of Facility: David J. Weber Funeral Homes PA 5311 Edmondson Avenue Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined
28a. Date of Injury (Month, Day Year): Found: 6-5-02
28b. Time of Injury: Unknown M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): In Vehicle
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1500 Washington Blvd., Baltimore, MD

29a. Certifier (Check only one): 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JUNE 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RNBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: Jeanne G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

John George Weidinger, III
02-3083-005
crm

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 070202:ITEMS#23a,27 per ME G809 ss

# Certificate of Death

Reg. No. 2002 18701

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| John G. Weidinger III | June 09 2002 | 8:25 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2130 Southorn Road | Hawthorne | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-42-2075 | 1 [X] M 2 [ ] F | 56 Yrs. | | | June 15 1045 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Hawthorne | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2130 Souththorne Road | 21220 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Carpenter | Synder Brothers Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John G. Weidinger Jr. | MArgaret Aerriken |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Evelyn Weidinger/wife | 2130 Souththorne Road Balitmroe MD 21220 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | DulaneyValleyCemetery | 6/14/2002 | Baltimore MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| R. Terry Connelly | ConnellyFuneralHomeofEssex 300 MAce Ave. Baltimore MD. 21221 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [X] Yes 2 [ ] No | 1 [X] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [X] Yes 2 [ ] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J. Alton Hosie, MD | O.C.M.E. | June 10, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18702

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Theotis Williams
2. Date of Death: Month JUNE Day 9 Year 2002
3. Time of Death: 17:00 M
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 246-30-1125
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6 10 28
9. Birthplace (State or Foreign Country): N.C.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1407 N. Potomac Street
10f. Zip Code: 21213
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Breeze Man
16b. Kind of Business/Industry: Beth Steel

17. Father's Name (First, Middle, Last): Charlie Williams
18. Mother's Name (First, Middle, Maiden Surname): Nettie Allen

19a. Informant's Name/Relationship (Type, Print): Lyna Williams Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1407 N. Potomac Street Baltimore MD 21213

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cem.
Date: 6-13-02
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: BALTIMORE MARYLAND 21202 MARCH F.H. EAST 1101 E. NORTH AVENUE

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration pneumonia — Approximate Interval Between Onset and Death: 7 hours
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Small bowel obstruction — 24 hours
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Enterococcal bacteremia
Candidal fungemia
Alzheimer's dementia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Nimalie Stone MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): June 9, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nimalie Stone M.D. Johns Hopkins Hospital Tower 110, Doctors Lounge 600 North Wolfe Street Baltimore, Maryland 21287

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18703

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| ANDRE | D. | WITHERSPOON | June 6 2002 | 117 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore City | NA |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-86-3683 | X 1 M 2 F | 38 Yrs. | | | 1 29 64 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | X 1 Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2635 Boone Street | 21218 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| X 1 Never Married 2 Married 3 Widowed 4 Divorced | X 1 Yes 2 No | 1 Yes X 2 No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10th Grade | | Prep Cook | B.C.C.C. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Bernard Witherspoon | Helen Cummings |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mother Helen Cummings Witherspoon | 2635 Boone Street Baltimore MD 21218 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | King Mem. Park | 6-12-02 | Randallstown MD |

21. Signature of Funeral Service Licensee: Francis [illegible]

22. Name and Address of Facility: BALTIMORE MARYLAND 21202
MARCH F.H. EAST 1101 E. North Avenue

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. MRSA Endocarditis | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HIV

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes X 2 No | 1 Yes X No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes X 2 No | Hospital: X 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| X 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): X 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [illegible] MD | RES000 | June 06, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sinai Hospital of Baltimore

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | [illegible] |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P1 Known as: Witherspoon, Andre RF

RR 2

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18704

Madlene Wodarczyk 24K

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036

Faxed to me 6/10/02

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**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Madlene Nellie Wodarczyk

2. Date of Death (Month, Day, Year): June 9, 2002

3. Time of Death: 6.10P M

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212 30 4057

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 6, 1932

9. Birthplace (State or Foreign Country): North Carolina

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 79 Henderson Road

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Geriatric Aide

16b. Kind of Business/Industry: Private Nursing

17. Father's Name (First, Middle, Last): William Andrew Blevins

18. Mother's Name (First, Middle, Maiden Surname): Edith Spencer

19a. Informant's Name/Relationship (Type, Print): Steven Wodarczyk (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12630 Eastern Avenue Baltimore Maryland 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gardens

Date: 6/12/02

20c. Location - City or Town, State: Baltimore County, Md

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Failure

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Congestive Heart Failure

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alcohol Abose / withdraw

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Amit Khosla

29c. License number: D 0057357

29d. Date signed (Month, Day, Year): 6/9/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Amit Khosla 9000 Franklin Square Drive Baltimore, MD. 21237

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: [signature]

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**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other then "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18705

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Elsie Veronica Waldvogel

2. Date of Death (Month, Day, Year): June 9, 2002

3. Time of Death: 5:20 PM M

4a. Facility Name (If not institution, give street and number): St. Agnes Nursing & Rehab Center

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 104-16-7072

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 27, 1922

9. Birthplace (State or Foreign Country): New Jersey

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3004 N. Ridge Road #603

10f. Zip Code: 21043

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Science Lab Aid

16b. Kind of Business/Industry: Baltimore County Schools

17. Father's Name (First, Middle, Last): William August Windsor

18. Mother's Name (First, Middle, Maiden Surname): Elsie Mueller

19a. Informant's Name/Relationship (Type, Print): Henry Waldvogel/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3004 N. Ridge Road #603 Ellicott City, MD 21043

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 6-10-02

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. lung Cancer — 2 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery (Month, Day, Year)

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Mild Dementia

23e. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death Check on one

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D50835

29d. Date signed (Month, Day, Year): June 10, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Dando MD 405 Frederick Road Baltimore MD 21228

15

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18706

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jerome Williams

2. Date of Death (Month, Day, Year): June 7, 2002

3. Time of Death: 6:20 PM M

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 217-20-8010

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 15, 1926

9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 513 Coover Road

10f. Zip Code: 21401

10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 5 +

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): College Professor

16b. Kind of Business/Industry: US Naval Academy

17. Father's Name (First, Middle, Last): Maurice Williams

18. Mother's Name (First, Middle, Maiden Surname): Bertha Bronstein

19a. Informant's Name/Relationship (Type, Print): Lelia K. Williams/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 513 Coover Road Annapolis, MD 21401

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 6-10-02

20c. Location - City or Town, State: Baltimore, MD

21. Signature of ~~Funeral~~ Service Licensee: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Traumatic Intracerebral Hemmorrhage — Due to (or as a consequence of): — 7 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Steven Resnick

29c. License number: D035494

29d. Date signed (Month, Day, Year): 6/7/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Resnick Anne Arundel Medical Center

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

# Certificate of Death

Reg. No. 2002 | 8707

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DAGMAR FETTERMAN-WASIK
2. Date of Death (Month, Day, Year): JUNE 7, 2002
3. Time of Death: 1:37 PM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-54-3704
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 52 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/18/50
9. Birthplace (State or Foreign Country): GERMANY

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1608 FRENCHS AVE.
10f. Zip Code: 21221
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: VIETNAM
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALES
16b. Kind of Business/Industry: OSTROWSKI'S

17. Father's Name (First, Middle, Last): FREDERICK SEDLACEK
18. Mother's Name (First, Middle, Maiden Surname): ZLATICA HOMOLA

19a. Informant's Name/Relationship (Type, Print): GENEVIEVE ZAORSKI
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 F LEMMON GROVE CT. COCKEYSVILLE, MD.21030

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BAYVIEW CREMATORY
Date: 6/12/02
20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: ▶ Michael Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY EDEMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☒ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D39215
29d. Date signed (Month, Day, Year): 6/7/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERIC TONER, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: ▶ [signature] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18708

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Helen M. Wohrna
2. Date of Death: Month 6 Day 5 Year 02
3. Time of Death: 10:45 PM

4a. Facility Name (If not institution, give street and number): Dulaney Towson Health Care Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-16-3674
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 20, 1908
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8800 Walther Blvd. #2112
10f. Zip Code: 21234
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PBX Operator
16b. Kind of Business/Industry: Hotel Switchboard

17. Father's Name (First, Middle, Last): Francis M. Kennedy
18. Mother's Name (First, Middle, Maiden Surname): Margaret King

19a. Informant's Name/Relationship (Type, Print): Margaret Wohrna/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8800 Walther Blvd. #2112 Baltimore, MD 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 6-6-02
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service License: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. s/p CVA's — Approx. Interval: > 14.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CAD. s/p MI.
Dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: G
29c. License number: D 57337
29d. Date signed (Month, Day, Year): 6/6/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. AGATE 3007 E Northern Parkway MD 21214

**State Registrar**

31. Date filed (Month, Day, Year): JUN 11 2002
32. Registrar's Signature: Sandra D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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Wohrna, Helen

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18709

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Lest)*: MILDRED PEABODY ATWATER
2. Date of Death Month Day Yeer: MAY 25, 2002
3. Time of Death: 12:30 AM
4e. Fecility Name *(If not institution, give street end number)*: WESTMINSTER NURSING HOME
4b. City, Town, or Location of Deeth: WESTMINSTER
4c. County of Deeth: CARROLL

**Funeral Director**

5. Social Security Number: 129-14-7304
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yeer)*: 9/8/1922
9. Birthplece *(Stete or Foreign Country)*: FLORIDA

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 518 OLD WESTMINSTER PIKE
10f. Zip Code: 21157
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: ADMINISTRATOR
16b. Kind of Business/Industry: TRAVEL AGENCY

17. Father's Name *(First, Middle, Last)*: CLIFFORD RUSSELL PEABODY
18. Mother's Name *(First, Middle, Maiden Sumeme)*: MILDRED GALE

19a. Informant's Name/Relationship *(Type, Print)*: ELIZABETH ANN ROSE DAUGHTER
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 1146 STURDIVANT DR., CAREY, N.C. 27511

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: ALL COUNTY CREMATION
Date: 5/26/02
20c. Location - City or Town, State: SYKESVILLE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Fecility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Intervel Between Onset end Death

Immediete Cause (Finel disease or condition resulting in death) e. Severe Congestive Cardiomyopathy — 1Year

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other eignificent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobecco use contribute to the ceuee of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physicien**: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or Investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 52035
29d. Date signed *(Month, Dey, Yeer)*: May 25 2002

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): BINU CHALICO 241 Stoney Avenue Dixon Building Westminster, MD 21157

**State Registrar**

31. Date filed *(Month, Dey, Yeer)*: MAY 28 2002
32. Registrar's Signature: [signature]

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 6

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18710

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Shakura Aliyya Ahmad
2. Date of Death: Month May, Day 24, Year 2002
3. Time of Death: 5:00am M
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 491-84-6054
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 24 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 4, 1978
9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 12637 Georgia Avenue #201
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Payroll Specialist
16b. Kind of Business/Industry: Clerical

17. Father's Name (First, Middle, Last): Pir Ahmad
18. Mother's Name (First, Middle, Maiden Surname): Vakila Thomas

19a. Informant's Name/Relationship (Type, Print): Mr. Pir Ahmad (Father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12637 Georgia Avenue #201 Silver Spring, MD 20906

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Mem. Park
Date: 5/29/02
20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: ▶ Brian L. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D0054566
29d. Date signed (Month, Day, Year): May 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. Bhogauile, M.D. 8609 2nd Avenue, Silver Spring, MD 20910

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

WJL 1

Robert Anthony Artman
02-2859-017
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18711

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Anthony Artman

2. Date of Death: Month May, Day 31, Year 2002

3. Time of Death: 3:19 A M

4a. Facility Name (If not institution, give street and number): Bicknell Road, one mile off Mason Springs Road

4b. City, Town, or Location of Death: Marbury

4c. County of Death: Charles

**Funeral Director**

5. Social Security Number: 531-06-1130

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 21 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 12, 1980

9. Birthplace (State or Foreign Country): Texas

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Marbury

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4505 Richard Lawrence Drive

10f. Zip Code: 20658

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Date: 2002-02

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Combat Engineer

16b. Kind of Business/Industry: USNG

17. Father's Name (First, Middle, Last): William Dennis Artman

18. Mother's Name (First, Middle, Maiden Surname): Anita Charlene Brown

19a. Informant's Name/Relationship (Type, Print): William D. Artman-Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4505 Richard Lawrence Drive, Marbury, MD 20658

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans' Cem

Date: 6-6-02

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: John P. Knisley MO1164

22. Name and Address of Facility: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 5/31/02

28b. Time of Injury: 0315 HRS M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject driven vehicle struck fixed objects

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State): Bicknell Road near Mason Springs Road Charles County Maryland

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): May 31, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 03 2002

32. Registrar's Signature: Bonnie G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18712

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Eugene Stephen Ammann | May 26, 2002 | 7:00 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 19212 St. Johnsbury Lane | Germantown | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-64-1880 | 1 [X] M 2 [ ] F | 48 Yrs. | | | June 24, 1953 | Washington, DC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Germantown | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 19212 St. Johnsbury Lane | 20874 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 1 | Crew Chief | Montgomery County Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Ammann | Mary Turner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Margaret V. Ammann / Wife | 19212 St. Johnsbury Lane, Germantown, MD 20874 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Metropolitan Crematory | May 28, 2002 | Alexandria, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ken R. Thomas. | Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cancer of Ampulla | Chronic |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [X] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| John Wallmark MD | 53177 | May 28, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John M. Wallmark, MD 9707 Medical Center Drive, #300, Rockville, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | Denise B. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Yobin Ayula
CJ
02-2616-027

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18713

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jose Antonio Ayala

2. Date of Death: Month: May; Day: 20; Year: 2002

3. Time of Death: 10:52 A.M

4a. Facility Name (If not institution, give street and number): 8891 Flowerstock Row

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: N/A

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 33 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2/8/69

9. Birthplace (State or Foreign Country): Honduras

Usual Residence of Decedent

10a. State: Md

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9009 Lambekin Lane

10f. Zip Code: 21045

10g. Citizen of What Country?: Honduras

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] Yes 2 [ ] No Specify: Honduras

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Antonio Ayala

18. Mother's Name (First, Middle, Maiden Surname): Maria Concepcion Mercules

19a. Informant's Name/Relationship (Type, Print): Isidro Ayala Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9009 Lambekin Lane Columbia, Md 21045

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Jardin De Paz

Date: 6/4/02

20c. Location - City or Town, State: Valladolid Lempira

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Snead Funeral Home & Cremation Service 5732 Georgia Ave NW Washington, DC 20010

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Blunt Force Injuries

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [✓] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 5/20/02

28b. Time of Injury: 10:30 M

28c. Injury at Work? 1 [ ] Yes 2 [✓] No

28d. Describe how injury occurred: Deceased struck multiple times

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Creekbed

28f. Location (Street and Number or Rural Route Number, City or Town, State): 8891 Flowerstock Rd.

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): May 21, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

02-2658-027
B.K.S
DELMAS B. BERRY

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18714

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| DELMAS BRYAN BERRY | MAY 22, 2002 | 10:55 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HOWARD COUNTY GENERAL HOSPITAL | COLUMBIA | HOWARD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-66-5911 | 1☐M 2☒F | 45 Yrs. | | | OCT 20, 1956 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | HOWARD | LAUREL | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 20 MEADOW LANE | 20723 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | MAINTENANCE WORKER | MAINTENANCE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| DELMAS BERRY | MARGARET JOAN HOUSE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. JOYCE ANNE BERRY (WIFE) | 20 MEADOW LANE LAUREL, MD 20723 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | SPRINGFIELD CEMETERY | 5/28/02 | SYKESVILLE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Brian D. Haight | HAIGHT FUNERAL HOME & CHAPEL PA (Box 195) SYKESVILLE, MD 21784 (410)-795-1400 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | O.C.M.E | MAY 23, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Howard Cate MD 111 Penn Street, Baltimore, Maryland 21201

WJL 8

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ Geneva G Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

Amend Items 2 & 4a 05/29/2002 per Physician, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18715

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ina Slagle Bandel

2. Date of Death (Month, Day, Year): ~~May 20, 2001~~ MAY 20 2002

3. Time of Death: 7:55pm

4e. Facility Name (If not institution, give street and number): ~~Charlestown Retirement Community~~ CHARLESTOWN RETIREMENT COMMUNITY

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-44-2097

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 25, 1909

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12875 Triadelphia Road

10f. Zip Code: 21042

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Martin William Slagle

18. Mother's Name (First, Middle, Maiden Surname): Annie Centenniel Reck

19a. Informant's Name/Relationship (Type, Print): Mr. Donald Bandel (Son)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12875 Triadelphia Road Ellicott City, MD 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): McKendree Cemetery

Date: 5/24/02

20c. Location - City or Town, State: West Friendship, MD

21. Signature of Funeral Service Licensee: ▶ Brian L. Haight

22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Stroke — Months

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other elgnificent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: ▶ MD

29c. License number: D47447

29d. Date signed (Month, Day, Year): May 21, 2002

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Andrew Cabris 711 Maiden choice Lane Catonsville Maryland 21228

**State Registrar**

31. Dete filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: ▶ Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law raquires that tha death certificata be excited within 24 hours after death.

**To the Funeral Director:** After this certificata has been signed by tha attending physician and completely filled in by tha funeral director, paga 2 should be detached for usa as tha burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

WJL 6

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18716

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): TAM DEANNA BIVENS
2. Date of Death (Month, Day, Year): MAY 21 2002
3. Time of Death: 1414 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 213-78-7707
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 38 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3-12-64
9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: SOMERSET
10c. City, Town or Location: PRINCESS ANNE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12101 S. COLLEGE PLACE
10f. Zip Code: 21853
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSING ASSISTANT
16b. Kind of Business/Industry: GENESIS ELDERCARE

17. Father's Name (First, Middle, Last): JAMES BIVENS
18. Mother's Name (First, Middle, Maiden Surname): BEATRICE HARRIS HAYES

19a. Informant's Name/Relationship (Type, Print): BEATRICE HAYES ~ MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.BOX 236 ~ DEAL ISLAND, MD. 21821

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): JOHN WESLEY UM CH.
Date: 5/25/02
20c. Location - City or Town, State: DEAL ISLAND, MD.

21. Signature of Funeral Service Licensee: Russell Ford
22. Name and Address of Facility: BENNIE SMITH FH 919 W. ISABELLA ST. SALISBURY, MD. 21801

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. WASTING SYNDROME
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. TERMINAL ACQUIRED IMMUNE DEFICIENCY SYNDROME
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] and M.D
29c. License number: D50759
29d. Date signed (Month, Day, Year): 05/21/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES FOLASHADE 108 PINE BLUFF RD., SALISBURY MD. 21801

**State Registrar**

31. Date filed (Month, Day, Year): MAY 24 2002
32. Registrar's Signature: [signature] G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

213-78-7707 5/21/02 14:14 Tam Bivens 38y.o.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18717

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| ANNA BELLE BRITTINGHAM | 05 / 24 / 02 | 0130 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-10-8211 | 1☐ M 2☒ F | 87 Yrs. | | | July 15,1914 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Salisbury | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1604 S. Kaywood Drive | 21804 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | - | Secretary | Board of Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Farlow | Daisy Gertrude Brittingham |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard Farlow/Nephew | 7871 Dogwood Blossom Rd., Severn, MD 21144 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Parsons Cemetery | 5/28/02 | Salisbury, MD |

21. Signature of Funeral Service Licensee: Kenneth M. Holloway

22. Name and Address of Facility: Holloway Funeral Home Professional Association, 501 Snow Hill Rd., Salisbury, MD 21804

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. [illegible] | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. [illegible] | years |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | 029349 | 5/24/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Robins, M.D. 1104 Healthway Dr. Salisbury, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5/24/02 0130 #314-10-8211 87 M Annabelle Brittingham

12 DQ

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18718

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Bessie Lowe Bailiff

2. Date of Death: Month May Day 28 Year 2002

3. Time of Death: 23:45 M

4a. Facility Name (If not institution, give street and number): Laurelwood Nursing Home

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

**Funeral Director**

5. Social Security Number: 214-42-1832

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 17, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: North East

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 424 Bailiff Road

10f. Zip Code: 21901

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Lowe, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Olive Shallcross

19a. Informant's Name/Relationship (Type, Print): Jake Bailiff/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 367 Bailiff Road, North East, Maryland 21901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bay View Cemetery

Date: May 31, 2002

20c. Location - City or Town, State: Bay View, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Crouch Funeral Home 127 South Main Street, North East, Maryland 21901

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident — Approximate Interval Between Onset and Death: Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b. Hypertension — Unknown

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Sachales MD

29c. License number: D0023322

29d. Date signed (Month, Day, Year): 5.29.02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S.S. Sachdev MD, 118 North St Suite 313, Elkton MD 21921

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: [signature] Brenda G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18719

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Conrad Baker
2. Dete of Death: Month May Day 29, Year 2002
3. Time of Death: 6:10PM
4e Facility Neme *(If not institution, give street end number)*: Bradford Oaks Nursing & Rehab Center
4b. City, Town, or Location of Deeth: Clinton
4c. County of Deeth: Prince Georges

**Funeral Director**

5. Social Security Number: 246-01-0975
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. lest birthdey)*: 83 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: July 2, 1918
9. Birthplace *(Stete or Foreign Country)*: NC

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Prince Georges
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 7520 Surratts Road
10f. Zip Code: 20735
10g. Citizen of Whet Country?: USA
11. Merital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 4; College (1-4or 5+):
16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Auto Body Repairman
16b. Kind of Business/Industry: Auto
17. Fether's Neme *(First, Middle, Lest)*: Wylie Joseph Baker
18. Mother's Name *(First, Middle, Maiden Surname)*: Nellie Baker
19a. Informant's Name/Relationship *(Type, Print)*: David Baker/Son
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 6105 Arbor St. Cheverly, MD 20785
20a. Methed of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Trinity Memorial Gar.
Date: 6/1/02
20c. Location - City or Town, State: Waldorf, MD.
21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Name end Address of Facility: AREHART-ECHOLS FUNERAL HOME, P.A. P.O. Box 567 LaPlata, MD 20646

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth)
e. Bladder Cancer — 6 mnths
Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Plece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es stated. 2 [ ] **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner steted.

29b. Signeture end title of certifier: William D Jenemy
29c. License number: D35206
29d. Date signed *(Month, Dey, Yeer)*: May 30, 2002

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): 11701 Livingston Road, Fort Washington MD.

**State Registrar**

31. Dete filed *(Month, Dey, Yeer)*: JUN 03 2002
32. Registrer's Signeture: Bernard G. Spencer

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18720

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| RICHARD I. BROWER | May 24, 2002 | 0530 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Memorial Hospital | Easton | Talbot |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 084-18-3406 | 1 [X] M 2 [ ] F | 77 Yrs. | | | JUNE 19 1924 | NEW YORK |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | TALBOT | EASTON | [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 201 FEDERAL ST., APT 85 | 21601 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | OWNER, OPERATOR | DRY GOODS STORE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| UNKNOWN | UNKNOWN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| GLEN L. HUNT/PERSONAL REP. | 55 PECAN TRAIL, SILER CITY, N. CAROLINA 27344 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | CHESAPEAKE CREMATION | CTR 5-30-02 | STEVENSVILLE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ JOHN R. MERCER | FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. pneumonia — 2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 [ ] Yes 2 [X] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sepsis
Liver cancer

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Harou Laura Jin | 00055484 | 5-24-2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
H. LAURA JIN M.D., 219 S. WASHINGTON ST. EASTON, MD 21601

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | Geneva G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Richard Brower

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

Amended#9, perF.H. - For State Registrar F.H., TCHD, 05/28/02, sbb

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

2002 18721

Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Richard Doremus Bond | May | 25 | 2002 | 12:50AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 203 N. MORRIS STREET | OXFORD | TALBOT |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 151-03-7110 | 1 X M 2 F | 91 Yrs. | | | SEPT. 9, 1910 | OHIO |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | TALBOT | OXFORD | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 203 N. MORRIS STREET | 21654 | U.S. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | SALES EXECUTIVE | AIR QUALITY CONTROL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| HARRY KELLER BOND | KATHERINE DOREMUS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ALMA T. MARTIEN / WIFE | P.O. BOX 370 OXFORD, MD 21654 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | CHES. CREM. CENTER | MAY 26, 2002 | CHESTER, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| M. E. Dewman III C.F.S.P. | FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Coronary Artery Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Dementia | |
| | Due to (or as a consequence of): c. Cerebrovascular Disease | |
| | Due to (or as a consequence of): d. Seizure Disorder | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 Yes 2 X No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 Yes 2 No 3 Probably 4 X Unknown | 1 Yes 2 X No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 X No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 X Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Paltoo M.D. | D0057040 | 05-25-2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BRENDON PALTOO 105 AURORA STREET CAMBRIDGE MD 21613

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | Jeanne D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

SBB

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18722

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gwendolyn E. Burrell

2. Date of Death (Month, Day, Year): May 25, 2002

3. Time of Death: 5:16 PM M

4a. Facility Name (If not institution, give street and number): Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 380-30-7927

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 26, 1932

9. Birthplace (State or Foreign Country): Michigan

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: New York

10b. County: New York

10c. City, Town or Location: New York

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 180 Riverside Drive #9B

10f. Zip Code: 10069

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administration Assistant

16b. Kind of Business/Industry: Teachers Union

17. Father's Name (First, Middle, Last): Dorsey M. Simmons

18. Mother's Name (First, Middle, Maiden Surname): Beatrice Hunter

19a. Informant's Name/Relationship (Type, Print): Jocelyn E. Burrell Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 115-T2 Timberbrook Ln., Gaithersburg, MD 20878

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: 5/29/02

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Thomas D. Clyburn

22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chitra Clyburn

29c. License number: D42452

29d. Date signed (Month, Day, Year): May 25, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chitra Rajagopal, M.D. 18111 Prince Phillip Dr. #327 Olney, MD 20832

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: James G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18723

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edwin M. Burnside

2. Date of Death (Month, Day, Year): May 27, 2002

3. Time of Death: 6:30 AM

4a. Facility Name (If not institution, give street and number): Forest Glen Skilled Nursing Center

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-22-6667

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 11, 1924

9. Birthplace (State or Foreign Country): DC

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4508 Gaynor Road

10f. Zip Code: 20906

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cable Splicer

16b. Kind of Business/Industry: Pepco

17. Father's Name (First, Middle, Last): Unknown Burnside

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Patricia Brashers / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10851 Bucknell Drive, Wheaton, MD 20902

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: May 30, 2002

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Eric S. Seeds

22. Name and Address of Facility: Francis J. Collins Funeral Home,Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Carcinoma of Prostate — 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Parkinson's Disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Myron L Lenkin MD

29c. License number: D06674

29d. Date signed (Month, Day, Year): May 28, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Myron L. Lenkin, MD 2309 Shorefield Road, Wheaton, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AMEND ITEM#5 PER INFMNT.
G809 7-2-02 JAB
AMEND #23a(d),5/28/2002,BMW,McCo

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18724

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Dete of Deeth Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Mildred | Bumgardner | May 19, 2002 | 3:15 PM |

| 4a Fecility Neme (If not institution, give street and number) | 4b. City, Town, or Locetion of Death | 4c. County of Deeth |
|---|---|---|
| St. Mary's Nursing Center | Leonardtown | St. Mary's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 281-16-~~1905~~ 8030 | 1☒ M 2☐ F | 96 Yrs. | | | May 27, 1905 | Ohio |

Usuel Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Locetion | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | St. Mary's | Mechanicsville | 1☐ Yes 2☒ No |

| 10e. Street end Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 25525 Frendship School Road | 20659 | U.S.A. |

| 11. Merital Status | 12. Was Decedent Ever in U,S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4 | Teacher | Public Schools |

| 17. Father's Neme (First, Middle, Lest) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Timothy Betz | Ethel Gooch |

| 19a. Informant's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| Marlene B. Thomas - Daughter | 25525 Frendship School Rd., Mechanicsville, MD20659 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Kirkland Memorial Gardens | 5/25/02 | Pt. Pleasant, WV |

| 21. Signeture of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Dennis Pottsmeier | Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 |

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

D

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hx Aspiration Pneumonia

Due to (or as a consequence of):
b. failure to thrive

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Due to (or es a consequence of):
c. coronary A. disease

Due to (or as a consequence of):
d. Hx- Gastrointestional Bleed ~~bleed~~

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

| 23b. Did tobacco use contribute to the cause of death? | 24a. Was en autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Menner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| A Shah | D 47066 | 5.20.02 |

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
A.D. Shah, MD 22335 Exploration Lane Lexington Park, Maryland

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Division of Vital Records, P.O. Box 68760,**

5

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signeture |
|---|---|
| MAY 28 2002 | B. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18725

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Bessie Jordan Bryn

2. Date of Death Month Dey Year: May 28, 2002

3. Time of Death: 4:00 AM

4a. Facility Name *(If not institution, give street and number)*: 3230 Spartan Road Unit #65

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 403-46-7356

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 4, 1914

9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Olney

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3230 Spartan Road Unit #65

10f. Zip Code:

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Operator

16b. Kind of Business/Industry: Bell South & ATT

17. Father's Name *(First, Middle, Lest)*: John Jordan

18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie Brooks

19a. Informant's Name/Relationship *(Type, Print)*: John Bryn - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 11388 Olney, MD 20830

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: South Jefferson Cemetery

Date: 6/4/02

20c. Location - City or Town, State: Louisville, KY

21. Signature of Funeral Service Licensee: Karen J. Woodall

22. Name and Address of Facility: Metropolitan Funeral Service 5517 Vine St. Alexandria, VA

**Physician /Medical Examiner**

23a. Part I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | Immediate |
| | Due to (or as a consequence of): Ischemic Cardiomyopathy | 2 Months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as e consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P Henjum MD

29c. License number: D35045

29d. Date signed *(Month, Day, Year)*: May 28, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Philip G. Henjum, MD 3516 Olandwood Ct. #204 Olney, MD 20832

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 31 2002

32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18726

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jesse E Bruce
2. Date of Death Month: MAY Day: 25 Year: 2002
3. Time of Death: 2:07 A M
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 216-18-0704
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 11, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5615 Tricross Drive
10f. Zip Code: 21045
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 5th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance Worker
16b. Kind of Business/Industry: Drexall Park Apartments

17. Father's Name (First, Middle, Last): John Bruce
18. Mother's Name (First, Middle, Maiden Surname): Rachel Cager

19a. Informant's Name/Relationship (Type, Print): Thelma Walker/ Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9294 Cartersville Rd Columbia, MD 21046

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hopkins Church Cem
Date: 6/1/2002
20c. Location - City or Town, State: Highland, MD

21. Signature of Funeral Service Licensee: Peggy R. Snowden
22. Name and Address of Facility: Snowden Funeral Home PA 245 N Washington St Rockville, MD 20850

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 5/25/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOOD 201-109 Back River Neck Rd Baltimore MD 21221

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

02-2[illegible]4-033
LESLIE L.BRICKNER
RKD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061202:ITEMS#23a,27,28a-f per ME G808 ss

# Certificate of Death

Reg. No. 2002 18727

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Leslie Lynn Brickner
2. Date of Death (Month, Day, Year): MAY 23, 2002
3. Time of Death: 2:43P. M
4a. Facility Name (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL CENTER
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE GEORGES

**Funeral Director**

5. Social Security Number: 548-49-6501
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 37 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 15, 1965
9. Birthplace (State or Foreign Country): Nebraska

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7200 Jaywick Ave.
10f. Zip Code: 20744
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Paul C. Heslop
18. Mother's Name (First, Middle, Maiden Surname): Maureen Evans

19a. Informant's Name/Relationship (Type, Print): Maureen Buhler (Mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 449 Creek View Lane Colonial Beach, VA 22443

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematoy
Date: 5/24/02
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Dennie Pittman
22. Name and Address of Facility: Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☒ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined
28a. Date of Injury (Month, Day Year) Found: 5-23-02
28b. Time of Injury Found: 1:30p M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 7200 Jaywick Ave., #612,Ft. Washington MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): MAY 24,2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002
32. Registrar's Signature: Jenna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18728

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Mya Jade Benoit | May 19, 2002 | 11:54 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Holy Cross Hospital | Silver Spring | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| None | 1☐M 2☒F | 0 Yrs. | | 11 / 38 | May 19, 2002 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Burtonsville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 30 Blackburn Court | 20866 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 0 | | None | None |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jerome Benoit | Carla Wright |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jerome Benoit/Father | 30 Blackburn Court, Burtonsville, MD 20866 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gate of Heaven | May 25, 2002 | Silver Spring, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ John P. Chaplin M00092 | Robert A. Pumphrey Funeral Home / Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hyaline Membrane Disease

Due to (or as a consequence of):

c. Extreme Immaturity

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumopericardium

Chorioamnionitis and Funisitis

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No |
|---|---|

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Matthew Picard M.D. | D0050522 | May 19, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Picard, M.D. 1500 Forest Glen Road, Silver SPring, Maryland 20910

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ Geneva G. Scarlett |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

6

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18729

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Oscar | Bonilla | May 27, 2002 | 6:00 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Genesis Eldercare- Layhill Center | Silver Spring | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. lest birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-39-2813 | 1 [X] M 2 [ ] F | 64 Yrs. | | | Sept 5, 1937 | El Salvador |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Silver Spring | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2712 Urbana Drive | 20906 | El Salvador |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [X] Yes 2 [ ] No Specify: Salvadorian | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Police Officer | Law Enforcement |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Antonio Bonilla | Rosario Hernandez |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lea Ruiz / Daughter | 2712 Urbana Drive, Silver Spring, MD 20906 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Gate of Heaven Cemetery | May 30, 2002 | Silver Spring, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| William L Boyd | Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory Failure

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d. Diabetes Type II

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

Bilateral Below knee amputation

Congestive Heart Failure

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 [ ] Yes 2 [ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| AJay Reddy | D 53691 | May 28, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AJay Reddy 6320 Democracy Blvd., Bethesda, MD 20817

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | Bonnie G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18730

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| RUTH C. BIEDERMAN | MAY 26, 2002 | 7:25 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| WASHINGTON ADVENTIST HOSPT. | TAKOMA PARK | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-03-8265 | 1☐ M 2☒ F | 86 Yrs. | | | JULY 5, 1915 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | MONTGOMERY | SILVER SPRING | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10000 BRUNSWICK AVE. #614 | 20910 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | LIBRARY ASSISTANT | LIBRARY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| SIMON K. CLAPPER | FLORENCE PRICE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MARY OWENS/DAUGHTER | 10 SILVER KETTLE CT., GAITHERSBURG, MD. 20878 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | CHAMBERS CREMATORY | 5-29-02 | RIVERDALE, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| W. W. Chambers MO0091 | 5801 CLEVELAND AVE.,RIVERDALE,MD. CHAMBERS FUNERAL HOME & CREMATORIUM,P.A. 20737 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ASPIRATION PNEUMONIA | 1 WEEK |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. NEUROGENIC DYSPHAGIA | 2 WEEKS |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERCAPNIA

PULMONARY EMBOLI

SPHENOID SINUS MASS LESION

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒ Yes 2☐ No | 1☐ Yes 2☒ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Thomas M. Annulis, M.D. | D0052401 | May 29, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS M. ANNULIS, M.D. 11120 NEW HAMPSHIRE AVE.#305, SILVER SPRING, MD. 20904

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | Geneva G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18731

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Bhagwan | Dass | Bhalla | May | 28 | 2002 | 1:15 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Shady Grove Adventist Hospital | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 190-78-1737 | 1 [X] M 2 [ ] F | 92 Yrs. | | | | | June 1, 1909 | India |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Germantown | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11500 Seneca Forest Circle | 20876 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: Asian Indian |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Business Owner | Advertisement |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| Ram P. Bhalla | Lajwanti Bajaj |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Yoginder P. Bhalla / Son | 11500 Seneca Forest Cir.; Germantown, MD 20876 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Chesapeake Crematory | June 1, 2002 | Beltsville, MD |

21. Signature of Funeral Service Licensee: Stephen D Lohrmann M00382

22. Name and Address of Facility: Rapp Funeral and Cremation Services Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, MD 20910

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Myocardial Infarction | 24 Hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): b. | Cerebrovascular Accident | 6 Hours |
| Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [X] No |

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check on one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 [X] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicaf Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| A Kuruvilla MD | D46187 | May 30, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ajit P. Kuruvilla M.D.; 11125 Rockville Pike, #208; Rockville, MD 20852

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 31 2002 | Geneva G. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-i show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospitel or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18732

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HAROLD BEANE
2. Date of Death (Month, Day, Year): MAY 28 2002
3. Time of Death: 1:00 AM
4a. Facility Name (If not institution, give street and number): Lorine Nursing Home
4b. City, Town, or Location of Death: Mt. Airy
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 213-01-5881
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 17, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: West Virginia
10b. County: Jefferson
10c. City, Town or Location: Harpers Ferry
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 341 Mara Rose Lane
10f. Zip Code: 25425
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: World War II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Automobile Salesman
16b. Kind of Business/Industry: Automobile Dealership

17. Father's Name (First, Middle, Last): William Beane
18. Mother's Name (First, Middle, Maiden Surname): Ada Lucinda (not available)

19a. Informant's Name/Relationship (Type, Print): Robert W. Beane/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 341 Mara Rose Lane, Harpers Ferry, WV 25425

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park — Date: May 31 2002
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: David E. Perry · M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) — MONTHS

Due to (or as e consequence of): PARKINSON'S DISEASE — MONTHS

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last:
b. — Due to (or as e consequence of):
c. — Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Signature MD
29c. License number: D0053150
29d. Date signed (Month, Day, Year): MAY 28 2002

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): SHAKUNTALA GUPTA 201-109 BACK RIVER NECK RD 21224 BALTIMORE

**State Registrar**

31. Dete filed (Month, Day, Year): MAY 30 2002
32. Registrer's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requiras that tha death cartificata be axecuted within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18733

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILLA SANDERS COTTERMAN
2. Date of Death (Month, Dey, Year): MAY 27, 2002
3. Time of Death: 7:11 AM
4a. Facility Name (If not institution, give street end number): WESTMINSTER NURSING HOME
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

**Funeral Director**

5. Social Security Number: 279-10-1665
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): 3/24/1917
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. Stete: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 706 EDEN FARM CIRCLE
10f. Zip Code: 21157
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Lest): WILLIAM SANDERS
18. Mother's Name (First, Middle, Maiden Surname): ELSIE BOWLES

19a. Informant's Name/Relationship (Type, Print): HAROLD F. COTTERMAN, III SON
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 706 EDEN FARM CIRCLE, WESTMINSTER, MD. 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other place): PINE GROVE CEMETERY
Dete: 5/30/02
20c. Location - City or Town, State: MT. AIRY, MD.

21. Signature of Funeral Service Licensee: Olin L. Molesworth
22. Name and Address of Fecility: OLIN L. MOLESWORTH, P.A. 26401 RIDGE RD., DAMASCUS, MD. 20872

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Intervel Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death): a. Cerebral Atherosclerosis — 6 yrs.

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert L. Moss, MD
29c. License number: 032982
29d. Date signed (Month, Day, Yeer): 5/27/02

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert L. Moss 114 Business Center Drive Reisterstown, Md 21136

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: Geneva G Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJC 2

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

# Certificate of Death

Reg. No. 2002 | 8734

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| CHARLES C. CAREY, SR. | MAY 21 2002 | 12:30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1110 HEALTHWAY DR. | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-10-8323 | 1☒M 2☐F | 82 Yrs. | | | SEPT. 22 1919 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | WICOMICO | SALISBURY | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1110 HEALTHWAY DR. | 21804 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | SALESMAN | OFFICE SUPPLIES |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| SAMUEL CRAWFORD CAREY | NETTIE FRANCES CHATHAM |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| SAMUEL W. CAREY - SON | 32099 HUNTLEY CIRCLE SALISBURY, MD 21804 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | PARSONS CEMETERY | 5/24/2002 | SALISBURY, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ B. Keith Pugsley CFSP | 705 E. MAIN ST. 21804 BOUNDS FUNERAL HOME, INC. SALISBURY, MD |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Prostate Carcinoma | Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Eclopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

A-FIB

| 23e. Did tobecco use contribute to the cause of death? | 24e. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
☒1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐2 **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D28769 | 5/22/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NICHOLAS N. BORODULIA, MD 1110 Healthway Drive Salisbury, Md 21804

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 23 2002 | ▶ [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospitel or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18735

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LURA CORNELIUS

2. Date of Death: Month MAY Day 19 Year 2002

3. Time of Death: 10:15 AM

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: 213-60-9454

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 11, 1952

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 27988 Cross Creek Drive

10f. Zip Code: 21801

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postal Clerk

16b. Kind of Business/Industry: US Postal Service

17. Father's Name (First, Middle, Last): Leonard Wilson Johnson

18. Mother's Name (First, Middle, Maiden Surname): Anna Lee Beverage

19a. Informant's Name/Relationship (Type, Print): Gary G. Cornelius/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27988 Cross Creek Dr., Salisbury, MD 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Wicomico Memorial Park

Date: 5/24/02

20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: David H. Compton, CFSP

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HERNIATION SYNDROME of BRAIN — 1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CEREBROVASCULAR ACCIDENT — 2 DAYS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SUBARACHNOID HEMORRHAGE

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P14630

29d. Date signed (Month, Day, Year): MAY 19, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EDWARD AHN, MD. DEPARTMENT OF NEUROSURGERY, 22 SOUTH GREENE ST., BALTIMORE, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAY 22 2002

32. Registrar's Signature: Denise G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10:4 mp DQ

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18736

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: ROBERT JOHN CORD, SR.

2. Dete of Deeth: Month MAY Dey 30 Year 2002

3. Time of Death: 10:00 AM

4a Feciility Neme *(If not institution, give street end number)*: 8365 ROUND HILL ROAD

4b. City, Town, or Location of Deeth: CHARLOTTE HALL

4c. County of Deeth: CHARLES

**Funeral Director**

5. Sccial Security Number: 218-01-2623

6. Sex: 1☒M 2☐F

7. Age *(In yrs. lest birthdey)*: 84 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: DEC. 11, 1917

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usuel Residence of Decedent

10a. Stete: MD

10b. County: CHARLES

10c. City, Town or Location: CHARLOTTE HALL

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 8365 ROUND HILL ROAD

10f. Zip Code: 20622

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: W.W.II

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: WEIGHTS & MEASURES INSPECTOR

16b. Kind of Business/Industry: COUNTY GOVERNMENT

17. Fether's Neme *(First, Middle, Last)*: HENRY WILLIAM CORD

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY ELIZABETH NICHOLSON

19a. Informant's Name/Reletionship *(Type, Print)*: MARY E. CORD / WIFE

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 8365 ROUND HILL ROAD CHARLOTTE HALL, MD 20622

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: FORT LINCOLN CEMETERY

Date: JUNE 3, 2002

20c. Locetion - City or Town, State: BRENTWOOD, MARYLAND

21. Signeture of Funerel Service Licensee: [signature]

22. Neme and Address of Feciility: BRINSFIELD-ECHOLS FUNL.HME.,P.A. 30195 THREE NOTCH RD CHARLOTTE HALL, MD 20622

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death)

e. CARCINOMA of STOMACH. — 4 MONTHS

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest

b. CONGESTIVE HEART FAILURE. — 4 months

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☒ **Unknown**

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature]

29c. License number: D20624

29d. Date signed *(Month, Dey, Yeer)*: 5/30/02

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): GEORGE WATHEN, M.D. 11345 PEMBROOKE SQUARE SUITE 103 WALDORF, MD 20601

**State Registrar**

31. Dete filed *(Month, Dey, Yeer)*: MAY 31 2002

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

ADH
BRUCE CARROLL
02-2678-041

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18737

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BRUCE MILTON CARROLL
2. Date of Death — Month: MAY Day: 23, Year: 2002
3. Time of Death: 1158 A M
4a. Facility Name (If not institution, give street and number): 1020 N. WASHINGTON STREET APT.#907
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

**Funeral Director**

5. Social Security Number: 212-56-1422
6. Sex: X M 2☐ F
7. Age (In yrs. last birthday): 51 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 16 1950
9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: XX Yes 2☐ No
10e. Street and Number: 1020 N. WASHINGTON ST., APT 907
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4 X Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONTRACTOR
16b. Kind of Business/Industry: FLOOR SERVICE

17. Father's Name (First, Middle, Last): MILTON THOMAS CARROLL
18. Mother's Name (First, Middle, Maiden Surname): JEANETTE D. SLAUGHTER

19a. Informant's Name/Relationship (Type, Print): BRENT T. CARROLL/BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO BOX 458 CENTREVILLE, MD 21617

20a. Method of Disposition: 1 X Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD VETERANS CEMETERY
Date: 5-29-2002
20c. Location - City or Town, State: HURLOCK, MD

21. Signature of Funeral Service Licensee: JOHN R. MERCERON
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cutting wounds to the face and wrists
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2 X No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2 X No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1 X Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2☐ No

25. Was case referred to medical examiner? 1 X Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5 X Residence 6☐ Other (Specify)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

27. Manner of Death: 1☐ Natural 2☐ Accident 3 X Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): 5-23-02
28b. Time of Injury: 11:57 M
28c. Injury at Work? 1☐ Yes 2 X No
28d. Describe how injury occurred: Deceased cut his face and wrists
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1020 N. Washington St.

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: OCME
29d. Date signed (Month, Day, Year): MAY 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: Denise B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit

SBB

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar: AMEND ITEM10A-C,E&F PER INFMNT G809 7-16-02 JAB

Reg. No. 2002 18738

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Susan Eugenia Cullather

2. Date of Death (Month, Day, Year): May 29, 2002

3. Time of Death: 10:49 AM

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 178-34-3607

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 25, 1912

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: ~~PA~~ MD.

10b. County: MONTGOMERY ~~Lackawanna~~

10c. City, Town or Location: ROCKVILLE ~~Scranton~~

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1235 POTOMAC VALLEY ROAD ~~4114 Division Street~~

10f. Zip Code: 20850 ~~18504~~

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Walter Hoolihan

18. Mother's Name (First, Middle, Maiden Surname): Pearl Roe

19a. Informant's Name/Relationship (Type, Print): Judy Mroczka, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 323 Washington Grove, Maryland 20880

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cathedral Cemetery

Date: June 1, 2002

20c. Location - City or Town, State: Scranton, PA

21. Signature of Funeral Service Licensee: Judy Mroczka

22. Name and Address of Facility: DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial Infarction — Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY Disease — Years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lymphoma

ALZheimer's Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jonathan Wenk

29c. License number: D0058025

29d. Date signed (Month, Day, Year): 5-29-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jonathan Wenk, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18739

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): KATHRYN B. COTTER
2. Date of Death (Month, Day, Year): May 26, 2002
3. Time of Death: 6:30pm

4a Facility Name (If not institution, give street and number): Sycamore Acres
4b. City, Town, or Location of Death: Derwood
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-38-3923
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 17, 1911
9. Birthplace (State or Foreign Country): Texas

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11011 Picasso Lane
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Assistant
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Henry J. Burke
18. Mother's Name (First, Middle, Maiden Surname): Margaret A. Cronin

19a. Informant's Name/Relationship (Type, Print): Margaret A. Cotter (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11011 Picasso Lane Potomac, Md. 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate fo Heaven Cemetery
Date: May 30, 2002
20c. Location - City or Town, State: Silver Spring, Md.

21. Signature of Funeral Service Licensee: ▶ Curtis E Day
22. Name and Address of Facility: DeVol Funeral Home 10 East deer Park Dr. Gaithersburg, Md. 20877

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. MYO CARDIAL INFARCTION
Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

DEMENTIA

TRANSIENT ISCHEMIC ATTACK

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Group Home

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert P Fields MD
29c. License number: D34740 (MD)
29d. Date signed (Month, Day, Year): May 29, 2002

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Dr. Robert P. Fields M.D. 18109 Prince Philip Dr. #275 Olney, Md. 20832

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002
32. Registrer's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18740

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Max | COHEN | May 26, 2002 | 7:30 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 15115 Interlachen Drive #220 | Silver Spring | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 093-16-7902 | 1☒M 2☐F | 90 Yrs. | | | July 27, 1911 | Poland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Silver Spring | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15115 Interlachen Drive #220 | 20906 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Grocery Store Owner | Grocery -- Food |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| (unknown) | (unknown) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sheldon Weiner, Son-In-Law | 4624 Winding Stone Circle, Olney, MD 20832 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mt. Lebanon Cemetery | 05/29/02 | Adelphi, MD |

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St., NW, Washington, DC 20012

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | CONGESTIVE HEART FAILURE | YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b. | CORONARY ARTERY DISEASE | YEARS |
| Due to (or as a consequence of): c. | CORONARY ATHEROSCLEROSIS | YEARS |
| Due to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Samuel Lucas | D 0005588 | 05/28/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMUEL LUCAS, MD 10313 GEORGIA AVENUE, SILVER SPRING, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | Geneva B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For Stete Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18741

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Edna Josephine Clem | May 22, 2002 | 5:25 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Rockville Nursing Home | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 557-30-9321 | 1☐ M 2☒ F | 97 Yrs. | | | Aug. 26, 1904 | Missouri |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Potomac | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10504 Unity Lane | 20854 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Clerk | Cleaning |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William T. Jackman | Edna Rena Munger |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| William J. Clem/Son | 10504 Unity Lane, Potomac, Maryland 20854 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Montgomery Crematorium | May 24, 2002 | Bethesda, Maryland |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| ▶ [signature] | M00198 | Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Stroke | Days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Bowel Obstruction | Days |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Large Hiatel Hernia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ Frauke Westphal MD | D0019785 | May 22nd, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Frauke Westphal, M.D. 809 Veirs Mill Road, Rockville, Maryland 20851

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | [signature] G. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND #8,5/31/2002,BMW,McCo

# Certificate of Death

Reg. No. 2002 18742

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| FLORIAN B. CLAIBORNE | MAY 27, 2002 | 6:10 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Springbrook Adventist Nursing & Rehab | Silver Spring | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 224-26-8541 | 1☐M 2☒F | 80 Yrs. | | | Nov. 4, ~~1911~~ 1921 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| VA | None | Petersburg | 1☐Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 129 McKeever Street | 23803 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Custodian | Dept. of Defense |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William W. Brooks | Louise Reaves |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Theresa McGill (Niece) | 11215 Oak Leaf Dr., #315, Silver Spring, MD 20901 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify) | Tucker Funeral Hm. | 5/27/02 | Petersburg, VA |

21. Signature of Funeral Service Licensee: George R. Saunders

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTIC COLON CANCER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. RENAL FAILURE
Due to (or as a consequence of):
c. DIABETES MELLITUS
Due to (or as a consequence of):
d. CORONARY ARTERY DISEASE

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

| 24a. Was an autopsy performed? 1☐Yes 2☑No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No |
|---|---|

| 25. Was case referred to medical examiner? 1☐Yes 2☑No | 26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify) |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| BDas, M.D. | M57952 | 5/28/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Babulal Das, M.D. Bowie Two Med. Parctice, Bowie, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | Denise G. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** Mary

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18743

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Lucy Elizabeth Callaway | May 25 2002 | 6:20 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| College View Center | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-14-7180 | 1☐M 2☒F | 82 Yrs. | | | Jun. 3, 1919 | Maryland |

**Usual Residence of Decedent**

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Silver Spring | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 815 Thayer Avenue | 20910 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Customer Service | Department Store |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William David Miller, Sr. | Margaret Ellen Haller |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sandra A. Freeman/Niece | 7102 Ridge Road, Frederick, Maryland 21702 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Montgomery Crematorium, Inc. | June 1, 2002 | Bethesda, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| David E. Perry M00803 | Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial infarction | 48 hrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| R. VanDelBush, M.D. | D0057461 | 5/26/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
610 9th Ave Brunswick MD 21716

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | Geneva B. Sparks |

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.: 2002 18744

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John Henry Callanan
2. Date of Death Month/Day/Year: May 24, 2002 — Time: 7:15PM
4a. Facility Name (If not institution, give street and number): 9706 Corkran Lane
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 579-22-7718
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 23, 1921
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9706 Corkran Lane
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dentist
16b. Kind of Business/Industry: Dentistry

17. Father's Name (First, Middle, Last): Henry Callanan
18. Mother's Name (First, Middle, Maiden Surname): Catherine Haggerty

19a. Informant's Name/Relationship (Type, Print): Thomas E. Callanan/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9706 Corkran Lane, Bethesda, MD 20817

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium
Date: May 28, 2002
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: William A. Pumphrey M01173
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home, Rockville, Inc., 300 W. Montgomery Avenue, Rockville, MD 20850

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Non-Small Cell Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D36797
29d. Date signed (Month, Day, Year): May 28, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Alan R. Sheff, M.D. 10215 Fernwood Road, Bethesda, MD 20817-1106

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18745

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| BETTY ANN VIOLA DAY | MAY 27, 2002 | 10:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2336 SAMS CREEK RD. | WESTMINSTER | CARROLL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-28-6635 | 1☐M 2☒F | 70 Yrs. | | | MAY 6, 1932 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | CARROLL | WESTMINSTER | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2336 SAMS CREEK RD. | 21157 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | SEAMSTRESS | MANUFACTURING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| ROGER JESSE LAMBERT | EMMA HILDEBRIDLE LAMBERT |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| WALTER ROY DAY -HUSBAND | 2336 SAMS CREEK RD.,WESTMINSTER, MD.21157 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | ALL COUNTY CREMATION | 5/28/02 | SYKESVILLE, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast CA — Due to (or as a consequence of): — 1yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d. —

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D37949 | May 25th 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander Bozdarevich MD 295 Seven Ave, Westminster, MD 21157

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | Geneva G Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

WJL 10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

Amend Item 20b per F.D. 05/29/2002, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18746

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Zoila Luz Betancourt De Campana

2. Date of Death: Month May, Day 28, Year 2002

3. Time of Death: 1:05 PM

4a. Facility Name (If not institution, give street and number): 2410 Wood Stream Court

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 040-50-9752

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): May 17, 2002

9. Birthplace (State or Foreign Country): Ecuador

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2410 Wood Stream Court

10f. Zip Code: 21042

10g. Citizen of What Country? Ecuador

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No Specify: Ecuadorian

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)
Elementary/Secondary (0-12): unknown
College (1-4or 5+): unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Lest): Benjamin Betancourt

18. Mother's Name (First, Middle, Maiden Surname): Zoila Hortensia Rodas

19a. Informant's Name/Relationship (Type, Print): Steven Ryder/ Son-in-law

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 2410 Wood Stream Court Ellicott City, MD 21042

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation, Inc.

Date: 6/17/2002 ~~5/1/2002~~

20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: ▶ J. Zumbrun

22. Name and Address of Facility: J.N. Zumbrun F.H. & Mon. Co. 6028 Sykesville Road Eldersburg, MD 21784

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG METASTASES — 14 months

Due to (or as e consequence of):
b. Breast Cancer — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) and manner es steted. 2☐ Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ Edward J. Lee MD

29c. License number: D23601

29d. Date signed (Month, Day, Year): 5/29/02

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Edward J. Lee, M.D. 11065 Little Patuxent Pkwy, Columbia MD 21044

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrer's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet tha death certificate be executed within 24 hours efter deeth.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

WJL 3

**Medical Certification: To Be Completed by Physician/Medical Examiner**

02-2657-045
B.K.S
MARY DOUGHERTY

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18747

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| MARY | GAIL | DOUGHERTY | MAY 22, 2002 | 0941 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL HOSPITAL | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-32-2259 | 1☐M 2☒F | 66 Yrs. | | | October 5,1935 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Mardela Springs | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 24825 Ocean Gateway | 21837 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | - | Sales Coordinator | Vacuum Cleaner Sales |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| John Edward Dolan | Charlotte Ann McGuire |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Deirdre Ann Dougherty/Daughter | PO Box 3423, Salisbury, MD 21802 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mardela Memorial Cemetery | 5/25/02 | Mardela Springs, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Multiple Injuries | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cardiovascular Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 5/22/02 | 0900 M | 1☐Yes 2☒No | Driver in auto accident |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Street | RT 50/Marquis Ave |

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | O.C.M.E | MAY 23, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 24 2002 | [signature] G Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

10 MP

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18748

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Belle Dupree
2. Date of Death (Month, Day, Year): May 25, 2002
3. Time of Death: 8:45 PM
4a. Facility Name (If not institution, give street and number): 29617 Backtown Road
4b. City, Town, or Location of Death: Trappe
4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 243-01-5319
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 7, 1908
9. Birthplace (State or Foreign Country): North Carolina

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: Trappe
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 29617 Backtown Road
10f. Zip Code: 21673
10g. Citizen of What Country?

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): Arthur Horne
18. Mother's Name (First, Middle, Maiden Surname): Betty Batts

19a. Informant's Name/Relationship (Type, Print): Mary Thorpe / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29617 Backtown Road, Trappe, Maryland 21673

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Horne & Ricks Cem.
Date: 06/02/2002
20c. Location - City or Town, State: Rocky Mount, N.C.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bennie Smith Funeral Home, 426 Dover Street, Easton, maryland 21601

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ALZHEIMERS DISEASE — 12 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Michael A. Moskewicz MD
29c. License number: D-16609
29d. Date signed (Month, Day, Year): MAY 29, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL A. MOSKEWICZ MD, 503 BYRN STREET, CAMBRIDGE MD 21613

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18749

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Elodina DeMata

2. Date of Death Month Day Year: May 25, 2002

3. Time of Death: 9:20 pM

4a. Facility Name *(If not institution, give street and number)*: Heartland Health Care Center

4b. City, Town, or Location of Death: Adelphi

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 577-88-0485

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 21, 1914

9. Birthplace *(State or Foreign Country)*: El Salvador

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Riverdale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5706 E. Pine Drive

10f. Zip Code: 20737

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No *Specify:* South American

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Pedro Senteno Chavez

18. Mother's Name *(First, Middle, Maiden Surname)*: Emilia Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Rafael Antonio Mata / Grandson

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3343 Hewitt Avenue, Apt 103, Silver Spring, MD20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: May 31, 2002

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Andrew J. Cole

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Intra cerebral hemorrhage

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicef Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul A. De Vore MD

29c. License number: D 01852

29d. Date signed *(Month, Day, Year)*: May 29, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul A. De Vore, MD 4203 Queansbury Road, Hyattsville, MD

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 30 2002

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospitel or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18750

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Norine Meta Daly | May 22, 2002 | 10:03 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Suburban Hospital | Bethesda | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 506-09-4998 | 1☐M 2☒F | 84 Yrs. | | | June 10, 1917 | Nebraska |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | North Bethesda | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5550 Tuckerman Lane #316 | 20852 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Carl M. Jorgensen | Meta Fredericksen |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia A. Bour/ Daughter | 4 Clapham Court Potomac Falls, Virginia 20165 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gate of Heaven Cemetery | May 28,2002 | Silver Spring,Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| M00335 | Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Stroke | 4 Days |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Carotid Atherosclerosis | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | MD56476 | 5/23/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Julio Shakela, M.D. 36 Convent Drive #408 Bethesda, Maryland 20892

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | Geneva G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4 Norine Daly May 22, 2002 12:23 PM

ADH
DAVID LYMAN DAUGHTY
02-2750-037

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 071502:ITEMS#23a,27 per ME G609 ss

# Certificate of Death

Reg. No. 2002 18751

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| David | Lyman | Doughty | MAY | 27, | 2002 | 1540 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 29449 CHARLOTTE HALL ROAD | CHARLOTTE HALL | SAINT MARY'S |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 226-58-7826 | X 1☐M 2☐F | 58 Yrs. | | | | | May 18, 1944 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | St. Mary's | Charlotte Hall | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 29449 Charlotte Hall School Road | 20622 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates 7-28-65 to 7-27-67 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Clerk | Grocery Store |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Morris Garland Doughty | Ada Lee Smith |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| David L. Doughty, Jr. (Son) | 3473 Butlers Bluff Drive Cape Charles, VA 23310 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Belle Haven Cemetery | 5-31-02 | Belle Haven, VA |

21. Signature of Funeral Service Licensee: Ellen L. Woodall

22. Name and Address of Facility: Doughty Funeral Home P.O. Box 633 Exmore, VA 23350

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | |
| Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | OCME | MAY 28, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANA RUBIO, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 11 2002 | Geneva B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18752

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Theresa Mae Ennals | MAY 19 2002 | 0040 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-44-7282 | 1☐M 2☒F | 54 Yrs. | | | July 29 1947 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Salisbury | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 501 South Curlew Road | 21801 | U.S.A |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Domestic | None |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Oliver Camphor | Helen Horsey |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Hope Grebos (Daughter) | 10436 Eagle Dr.Princess Anne,Md.21853 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Green Acres | 5-25-02 | Salisbury,Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gladys B. Stewart | Stewart Funeral Home 821 West Rd.Salisbury,Md.21801 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC ADENOCARCINOMA PROBABLY LUNG ORIGIN
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b. Due to (or es a consequence of):
c. Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No |
|---|---|

| 25. Was case referred to medical examiner? 1☐Yes 2☒No | 26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |
|---|---|

| 27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ KUMAR RAJAGOPALAN, MD | D0051806 | 05/20/2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KUMAR RAJAGOPALAN, M.D. 100 E. CARROLL ST. SALISBURY MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 23 2002 | ▶ G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Age 54 5/19/02 00:40
Theresa Ennals 215-44-7282

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18753

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Charles Allen Edwards
2. Date of Death: Month June, Day 2, Year 2002
3. Time of Death: 2314 M
4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 237-50-5078
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Dec. 30, 1937
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 300 Mt. Royal Avenue
10f. Zip Code: 21001
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Vietnam
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): Six Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PKG Specialist
16b. Kind of Business/Industry: Aberdeen Proving Ground Aberdeen, Maryland

17. Father's Name (First, Middle, Last): Homer William Edwards
18. Mother's Name (First, Middle, Maiden Surname): Pearl West Moreland

19a. Informant's Name/Relationship (Type, Print): Joan L. Edwards
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 Mt. Royal Avenue, Aberdeen, Maryland 21001

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hopewell Cemetery
Date: 06/07/02
20c. Location - City or Town, State: Port Deposit, Maryland

21. Signature of Funeral Service Licensee: Thomas M. Patterson, Sr.
22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC LUNG CANCER — 3 1/2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joan P. Edwards MD
29c. License number: D31775
29d. Date signed (Month, Day, Year): JUNE 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOAN P. EDWARDS, M.D. 2112 BELAIR ROAD FALLSTON, MARYLAND 21047

**State Registrar**

31. Date filed (Month, Day, Year): JUN 04 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2314 6/2/02

Edwards, Charles Allen

10+IVA

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18754

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| CHARLES UROS ERDELJON | MAY 23 2002 | 5:20 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| NATIONAL NAVAL MEDICAL CENTER | BETHESDA | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 290-14-1311 | 1☒M 2☐F | 82 Yrs. | | | Dec. 9, 1919 | Ohio |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Rockville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 13512 Bartlett Street | 20853 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1942-1978 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Pharmacist | Veterans Administration and Public Health |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Emil Erdeljon | Zorka Perrin |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Eleanor E. Erdeljon/wife | 13512 Bartlett Street, Rockville, MD 20853 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Arlington Nat'l Cemetery | July 1, 2002 | Arlington, Virginia |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ John F. Chapple M00092 | Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ W.M.WANG, M.D. | 02002371A (IN) | 05/24/2002 |

| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | |
|---|---|
| W.M.WANG, LT, MC, USN | NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 |

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ Jennie G. Lowe |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12+1

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND #24a,6/5/02,per MD,MoCo — *Certificate of Death* — Reg. No. 2002 18755

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Nadia El Khadem | May 27, 2002 | 2:30 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 4948 Sentinel Drive #101 | Bethesda | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 301-54-1409 | 1☐M 2☒F | 74 Yrs. | | | March 4,1928 | Egypt |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Bethesda | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4948 Sentinel Drive #101 | 20816 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No *Specify:* | *Specify:* White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4 | Teacher | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Mahmod Said | Samiha Riaz |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Hassan El Khadem/Husband | 4948 Sentinel Drive # 101 Bethesda, MD 20816 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Cairo, Egypt | June 1,2002 | Cairo, Egypt |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 10 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Primary Lateral Sclerosis | 7 yrs. |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | 14603 | May 28, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Theodore C.M. Li, M.D. 3301 New Mexico Ave., N.W. Wash, D.C. 20016

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18756

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Arthur Jennings Forsyth

2. Date of Death (Month, Day, Year): May 22 2002

3. Time of Death: 10:03pm

4a. Facility Name (If not institution, give street and number): Charlestown Retirement Health Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212-16-8479

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 13 1912

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 715 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): director of sales

16b. Kind of Business/Industry: Dale Carnegie Institute

17. Father's Name (First, Middle, Last): John Forsyth

18. Mother's Name (First, Middle, Maiden Surname): Mary Maxwell

19a. Informant's Name/Relationship (Type, Print): Mary Forsyth Matthews (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19000 Gunpowder Rd., Millers, Md 21102

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Springfield Cemetery

Date: 5-24-02

20c. Location - City or Town, State: Sykesville, Md

21. Signature of Funeral Service Licensee: Brian L. Haight

22. Name and Address of Facility: Haight Funeral Home & ChAPEL P.O. Box 195 Sykesville, Md 21784

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Stroke — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D47447

29d. Date signed (Month, Day, Year): May 24, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Andrew Lagris 711 Maiden Choice Ln Catonsville Maryld 21228

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

WJL 1+1VA

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18757

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| FRANKY | WIDGEON | FRIES | MAY 18, 2002 | 1055 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-10-2234 | 1☐M 2☒F | 84 Yrs. | | | July 18, 1917 | Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Salisbury | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1107 S. Schumaker Dr., #207 | 21804 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | - | Homemaker | Domestic |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Royal Sinclair Widgeon | Mary Arnett Crawford |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Judith Dashiell/Daughter | 5356 Royal Mile Blvd., Salisbury, MD 21801 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Parsons Cemetery | 5/21/02 | Salisbury, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Keith R Kearney CFSP | Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CONGESTIVE HEART FAILURE | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. ATRIAL FIBRILLATION | |
| | Due to (or as a consequence of): | |
| | c. CVA | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HIP FRACTURE SECONDARY TO OSTEOPOROSIS

ARTERIAL EMBOLUS LEFT LEG

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Brandon | D38138 | MAY 22, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS BRANDON, M.D. 111 DAVIS ST. SALISBURY MD 21804

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 22 2002 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

FRANKY FRIES 217 10 2234

10 DQ

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18758

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): NANCY LEE HICKS FAEBUS

2. Date of Death (Month, Day, Year): May 24 2002

3. Time of Death: 5:00a M

4a. Facility Name (If not institution, give street and number): 407 Cannon St.

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

**Funeral Director**

5. Social Security Number: 213-60-7676

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 18 1942

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 407 Cannon St.

10f. Zip Code: 21620

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Walter Leo Hicks

18. Mother's Name (First, Middle, Maiden Surname): Catherine Elizabeth Faulkner

19a. Informant's Name/Relationship (Type, Print): Richard C. Faebus (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 407 Cannon St. Chestertown, MD. 21620

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Busick Cemetery

Date: 5-28-02

20c. Location - City or Town, State: Barclay, MD.

21. Signature of Funeral Service Licensee: M00510

22. Name and Address of Facility: Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO Pulmonary Arrest

Due to (or as a consequence of):

b. Metastatic Left Breast Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J.C. Ambrose Jr. M.D

29c. License number: D23889

29d. Date signed (Month, Day, Year): 5/24/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C. Ambrose JR, M.D 223 High Street Chestertown Md 21620

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002

32. Registrar's Signature: Jeanne G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-t show any injury or other traumatic event, the Medical Examiner must be notified at once.

10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18759

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HARRY W. FARMER, SR.
2. Date of Death: Month MAY Day 22 Year 2002
3. Time of Death: 09:20 AM
4a. Facility Name (If not institution, give street and number): CALVERT MANOR HEALTHCARE CENTER
4b. City, Town, or Location of Death: RISING SUN
4c. County of Death: CECIL

**Funeral Director**

5. Social Security Number: 167-12-6525
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): JANUARY 3, 1925
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: PA.
10b. County: CHESTER
10c. City, Town or Location: KIRKWOOD
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 16 JOHN DRIVE
10f. Zip Code: 17536
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): NONE
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MECHANICAL SUPERVISOR
16b. Kind of Business/Industry: MUNICIPAL WATER CO.

17. Father's Neme (First, Middle, Lest): JAMES FARMER
18. Mother's Name (First, Middle, Maiden Surname): BEATRICE WALTMAN

19a. Informant's Name/Relationship (Type, Print): JEAN FARMER - WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 16 JOHN DRIVE KIRKWOOD, PA 17536

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): OXFORD CEMETERY
Date: 5/25/02
20c. Location - City or Town, State: OXFORD, PA.

21. Signature of Funeral Service Licensee: Edward McGowan
22. Name and Address of Facility: RUFFENACH - 224 PENN AVE. OXFORD, PA. 19363

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Parkinson's Disease — Yrs.

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part It. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic cardiovascular disease; Hypertension; Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Steven A Levenson MD
29c. License number: D18186
29d. Date signed (Month, Day, Yeer): May 29, 2002

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Steven Levenson MD 515 Fairmount Av, 8th Fl, Balt MD 21204

**State Registrar**

31. Dete filed (Month, Day, Year): MAY 30 2002
32. Registrer's Signature: Jeanine G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18760

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| ILAR D. FREEMAN | 05 / 28 / 2002 | 10:15P pm |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical System | Baltimore | Baltimore City |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 334-30-4524 | 1☐M 2☒F | 66 Yrs. | | | Dec. 17, 1935 | Illinois |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Kent | Worton | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 24970 Lambs Meadow Road | 21678 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Instructional Aide | of Kent County Board Ed. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Thomas Hatcher | Mary Roundtree |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Clyde D. Freeman/Husband | 24970 Lambs Meadow Road, Worton, Maryland 21678 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mt. Olive Cemetery | 06/05/2002 | Butlertown, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Multidrug resistant Klebsiella bacteremia | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Sacral Decubitus Ulcer | |
| | Due to (or as a consequence of): | |
| | c. Anoxic Brain Injury | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease
Pleural Effusions

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | P14703 | 5/28/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
20 South Greene Street Baltimore, MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 31 2002 | ▶ Jeanne G. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18761

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John Edward Ford
2. Date of Death: Month May Day 26, Year 2002
3. Time of Death: 4:20 AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-38-0821
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 28, 1926
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3449 Dartmoor Lane
10f. Zip Code: 20832
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): Keefer Ford
18. Mother's Name (First, Middle, Maiden Surname): Edna Adams

19a. Informant's Name/Relationship (Type, Print): Linda S. Horenstein / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3449 Dartmoor Lane Olney, Maryland 20832

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: May 31, 2002
20c. Location - City or Town, State: Silver Spring

21. Signature of Funeral Service Licensee: John P Chaplin M00092
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. ISCHEMIC CARDIOMYOPATHY
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS
ATRIAL FIBRILLATION
RENAL INSUFFICIENCY

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one) Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Fields MD
29c. License number: D34740 (MD)
29d. Date signed (Month, Day, Year): 5/26/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT FIELDS, MD 18109 PRINCE PHILIP DRIVE #275 - OLNEY, MD 20832

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18762

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CHARLES ARTHUR FORBUSH JR
2. Date of Death Month Day Year: MAY 24 2002
3. Time of Death: 12:11 PM
4a. Facility Name (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 031-18-8678
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): NOV 6 1926
9. Birthplace (State or Foreign Country): MASSACHUSETTS

Usual Residence of Decedent

10a. State: VA
10b. County: FAUQUIER
10c. City, Town or Location: BEALETON
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11241 LIBERTY COURT
10f. Zip Code: 22712
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944 - 1966
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EVALUATOR
16b. Kind of Business/Industry: DEPT OF DEFENSE

17. Father's Name (First, Middle, Last): CHARLES ARTHUR FORBUSH
18. Mother's Name (First, Middle, Maiden Surname): EMILY MAE ROBERTS

19a. Informant's Name/Relationship (Type, Print): EDNA M. FORBUSH/WIFE
19b. Maiing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11241 LIBERTY COURT BEALETON VA 22712

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): NO VA FUNERAL SERVICES
Date: MAY 29 '02
20c. Location - City or Town, State: CHANTILLY VA

21. Signature of Funeral Service Licensee: Tom Rock
22. Name and Address of Facility: NORTHERN VIRGINIA FUNERAL SERVICE 14522L LEE ROAD CHANTILLY VA 20151-1639

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COLON CANCER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W M Wang / M.D.
29c. License number: 02002371A (IN)
29d. Date signed (Month, Day, Year): 05/28/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.M.WANG, LT, MC, USNR
NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18763

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Margaret Catherine Fierthaler | May 21, 2002 | 8:10A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Edenton Retirement Community | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 051-09-6682 | 1☐ M 2☒ F | 86 Yrs. | | | June 3, 1915 | New York |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Silver Spring | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1405 Pillock Place | 20905 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Clerk | Telecommunications Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Richard Meyer | Catherine Donner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary C. Shugrue / Daughter | 1405 Pillock Place, Silver Spring, MD 20905 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Calverton National Cemetery | May 24, 2002 | Calverton, Long Island, NY |

21. Signature of Funeral Service Licensee ▶ John E. Fahey

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Aspiration Pneumonia | 3 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Alzheimer's Disease | 10 years |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Infected Sacral Decubetus Ulcer

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Assisted Living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Shah Hiren, MD | D51643 | 5/22/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 170 Thomas Johnson Dr #100 Frederick MD 21702

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | ▶ Geneva B. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** MEM

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18764

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Adella Gordon | May 23, 2002 | 11:15P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Springbrook Adventist Nursing Home | Silver Spring | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-78-0334 | 1 ☐ M 2 ☒ F XX | 88 Yrs. | | | March 25, 1914 | Jamaica |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Silver Spring | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3119 Beaverwood Ln. | 20906 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Isaac McDermott | Ada Sewel |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| David Delapenha-Son | 14292 Town Commons Way Gainsville, VA 20155 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Parklawn Mem. Park | 05/28/2002 | Rockville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 4 Days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Impaired Gag Reflex | Many Yrs. |
| | Due to (or as a consequence of): c. Multiple Strokes | Many Yrs. |
| | Due to (or as a consequence of): d. Hypertension | Many Yrs. |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Type II, Dementia,

Muscle Contractures

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D31001 | May 24, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stuart J. Turkewotz, M.D. 7500 Greenway Drive; Greenvelt, MD 20770

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18765

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Garnett Marie Hutchens | June 2 2002 | 5:58 PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Laurelwood Nursing Home | Elkton | Cecil |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 231-16-1171 | 1☐M 2☒F | 83 Yrs. | | | April 30, 1919 | West Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Cecil | Elkton | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 100 Laurel Drive | 21921 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Homemaker | Own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Henry Harrison Sizemore | Jenett Jo Jackson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dewey Hutchens/ Son | 67 Salem Church Road, Newark, Delaware 19713 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gracelawn Memorial Park | June 6, 2002 | New Castle, Delaware |

21. Signature of Funeral Service Licensee ▶ Robert E. Crouch

22. Name and Address of Facility Crouch Funeral Home
127 South Main Street, North East, Maryland 21901

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Nephropathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☑No |

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | 056820 | 06/02/2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSIAH M. NISNISAN MD 223 WEST MAIN ST. ELKTON, MD 21921

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 04 2002 | ▶ Geneva P Sparks |

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2002 18766

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ALFRED MASON HADDAWAY
2. Date of Death — Month: May; Dey: 28; Year: 2002
3. Time of Death: 10:50 PM
4a. Facility Name *(If not institution, give street end number)*: Genesis ElderCare - The Pines
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 219-07-5448
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 86 Yrs.
If Under 1 Year — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Date of Birth *(Month, Day, Year)*: AUG 18 1915
9. Birthplace *(State or Foreign Country)*: MD

Usuel Residence of Decedent

10a. Stete: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 640 MECKLENBERG AVE.
10f. Zip Code: 21601
10g. Citizen of What Country?: USA
11. Meritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+): 0
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TECHNICIAN
16b. Kind of Business/Industry: HEATING & COOLING
17. Father's Neme *(First, Middle, Last)*: CALVIN M. HADDAWAY
18. Mother's Name *(First, Middle, Maiden Surname)*: MAUDE COOK
19a. Informant's Name/Relationship *(Type, Print)*: RICHARD M. HADDAWAY/SON
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 17212 BROWN RD., POOLSVILLE, MD 20837
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SPRING HILL CEMETERY
Date: 5-31-2002
20c. Location - City or Town, State: EASTON, MD
21. Signature of Funeral Service Licensee: JOHN R. MERCER
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA. 200 S. HARRISON ST., EASTON, MD 21601

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — immediate

Due to (or as e consequence of):
b. HYPOXIA — hours.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
Due to (or as e consequence of):
c. PNEUMONIA — days

Due to (or as e consequence of):
d.

Part II. **Other elgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HTN
ANEMIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: D.O.
29c. License number: H4818
29d. Date signed *(Month, Dey, Year)*: 5-29-2002

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): PATRICK M. STERLING 508 Idlewild Ave EASTON MD 21601

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 30 2002
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Alfred Haddaway
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

S&B

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- AMEND#7,5/31/02,MoCo Amend#4a,4b,10e,5/29/02,mgm mo.co. State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18767

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| DAVID | LEE | HORTON | MAY 25, 2002 | 9:30 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 4313 KNOX RD. ~~#416~~ #418 | ~~COLLEGE~~ College PARK | PRINCE GEORGES |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 477-32-6204 | 1[X] M 2[ ] F | ~~69~~ 68 Yrs. | | | DEC. 18, 1933 | MICHIGAN |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | PRINCE GEORGES | COLLEGE PARK | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4313 KNOX RD. ~~#416~~ #418 | 20740 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[ ] Never Married 2[ ] Married 3[ ] Widowed 4[X] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | PROFESSOR | UNIVERSITY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| HAROLD M. HORTON | ESTHER PETERSON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CHRISTOPHER DAVID HORTON/SON | 95 YORKSHIRE PL., NEWNAN, GA. 30265 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[ ] Burial 2[X] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | CHAMBERS CREMATORY | 5-29-02 | RIVERDALE, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ W. W. Chambers MO0091 | 5801 CLEVELAND AVE., RIVERDALE, MD. CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 20737 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ALCOHOLISM | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. CORONARY ARTERY DISEASE | |
| | Due to (or as a consequence of): c. HYPERTENSION | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown | 23c. If yes, outcome of pregnancy 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERLIPIDEMIA

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

| 24a. Was an autopsy performed? 1[ ] Yes 2[X] No | 24b. Were autopsy findings available prior to completion of cause of death? 1[ ] Yes 2[ ] No |
|---|---|

| 25. Was case referred to medical examiner? 1[X] Yes 2[ ] No | 26. Place of Death (Check only one) Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[X] Residence 6[ ] Other (Specify) |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | | M | 1[ ] Yes 2[ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Thomas F. Hattar MD | D0050321 | 05/28/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS F. HATTAR, M.D. 2009 TIDEWATER COLONEY DR., ANNAPOLIS, MD. 21401

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | ▶ Geneva B. Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18768

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Michelle R. Hamilton | May 22, 2002 | 11:11 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington Adventist Hospital | Takoma Park | Montgomery |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 113-42-8743 | 1☐M 2☒F | 51 Yrs. | | | Sept. 12, 1950 | New York |

**Funeral Director**

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Montgomery | Silver Spring | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 111616 Lockwood Dr., Apartment 204 | 20904 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Chef | Food Service |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Ernest Edgar Hamilton | Edna May Felisbret |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| David A. Hamilton/ Son | 22 Fox Hollow Lane, Sicklerville, NJ 08081 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Loudon Park Crematory | May 26, 2002 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiac Arrest | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Coronary Artery Disease | |
| | Due to (or as a consequence of): c. Diabetes | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D48083 | May 28, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Irving Westney, 7600 Carroll Ave, Takoma Park, MD 20912

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | Geneva B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit (1)

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18769

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Blanche Louise Hall
2. Date of Death (Month, Day, Year): May 24, 2002
3. Time of Death: 11:50 AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 233-42-8472
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 1, 1928
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1021 Scott Avenue
10f. Zip Code: 20851
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Noone
18. Mother's Name (First, Middle, Maiden Surname): Ada Rinehart

19a. Informant's Name/Relationship (Type, Print): Edward W. Hall/ Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1021 Scott Avenue, Rockville, Maryland 20851

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: May 27,2002
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service License: ▶ [signature] M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Embolism — 6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Christopher Mays M.D.
29c. License number: D39793
29d. Date signed (Month, Day, Year): May 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher J. Mays, MD, 18111 Prince Philip Drive #328 Olney, MD 20832

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

# Certificate of Death

Reg. No. 2002 18770

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MABEL I. INGRAM

2. Date of Death (Month Day Year): MAY 29, 2002

3. Time of Death: 12:25 PM

4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 235-22-0077

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 31,1921

9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: WHEATON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3512 EVERTON ST.

10f. Zip Code: 20906

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Father's Name *(First, Middle, Last)*: T. RAY HORNER

18. Mother's Name *(First, Middle, Maiden Surname)*: UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: RAY INGRAM/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3512 EVERTON ST., WHEATON, MD. 20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHAMBERS CREMATORY

Date: 5-30-02

20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers MO0091

22. Name and Address of Facility: 5801 CLEVELAND AVE.,RIVERDALE,MD. CHAMBERS FUNERAL HOME & CREMATORIUM,P.A. 20737

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

10

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. DEHYDRATION — 72 HRS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. SEPSIS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MESENTERIC ARTERY INSUFFICIENCY

SEVERE OSTEOPOROSIS

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Myron L Lenkin MD

29c. License number: D06674

29d. Date signed *(Month, Day, Year)*: MAY 29, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type. Print): MYRON L. LENKIN, M.D. 2309 SHOREFIELD RD., WHEATON, MD. 20902

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 31 2002

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18771

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Garland Berdan Jones

2. Date of Death: Month May Day 25 Year 2002

3. Time of Death: 2:40 AM.M

4a. Facility Name (If not institution, give street and number): 2720 Snow Hill Rd.

4b. City, Town, or Location of Death: Girdletree

4c. County of Death: Worcester

**Funeral Director**

5. Social Security Number: 214-28-3736

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5-13-1918

9. Birthplace (State or Foreign Country): Md.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Md.

10b. County: Worcester

10c. City, Town or Location: Girdletree

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 2720 Snow Hill Rd.

10f. Zip Code: 21829

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1944-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Post Master

16b. Kind of Business/Industry: US Post Office

17. Father's Name (First, Middle, Last): Garland D. Jones

18. Mother's Name (First, Middle, Maiden Surname): Ada Berdan Jones

19a. Informant's Name/Relationship (Type, Print): Mabel Jones, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2720 Snow Hill Rd. Girdletree, Md. 21829

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Cemetery

Date: 5-28-02

20c. Location - City or Town, State: Girdletree, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hepatocellular carcinoma — Due to (or as a consequence of): 1 yr —

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cryptogenic cirrhosis — Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Routenberg

29c. License number: D0015857

29d. Date signed (Month, Day, Year): 5/28/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Routenberg, M.D., 205 S. Division St., Salisbury, Md.21804

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10 MP

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#7,05-28-02,WCHD,dq

# Certificate of Death

Reg. No. 2002 18772

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Blanche Jackson

2. Date of Death: Month 5 Day 26 Year 2002

3. Time of Death: 650 P M

4a. Facility Name (If not institution, give street and number): University of Maryland Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-32-1090

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): ~~65~~ 66 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-11-1936

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Worcester

10c. City, Town or Location: Newark

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8532 Langmaid Road

10f. Zip Code: 21841

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: U.S. Post Office

17. Father's Name (First, Middle, Last): James Byron Disharoon

18. Mother's Name (First, Middle, Maiden Surname): Henrietta Hudson Disharoon

19a. Informant's Name/Relationship (Type, Print): Avery Richardson Jackson, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8532 Langmaid Rd. Newark, Md. 21841

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bowen U.M. Church Cem.

Date: 5-30-02

20c. Location - City or Town, State: Newark, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Vascular accident — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Thoracic aortic aneurysm — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death: 2 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P. Sean Van Zijl M.D.

29c. License number: P15884

29d. Date signed (Month, Day, Year): 5/26/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. Sean Van Zijl M.D. 22 South Greene St. Baltimore MD. 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

2 of 2 pg

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18773

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| John | Edward | Johnson, Jr. | 5 | 27 | 02 | 10:15 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Magnolia Hall Nursing Home | Chestertown | Kent |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 218-16-9884 | 1 M 2 F | 77 Yrs. | | | | | Aug. 7, 1924 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Kent | Millington | 1 Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| P.O. Box 402 | 21651 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 No If Yes, Give Year or Dates: | 1 Yes 2 No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | Sanitation Specialist | Sanitation |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Edward Johnson, Sr. | Annie Mae Plater |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John Lamonte Demby/Grandson | 254 Ron's Way, Smyrna, Delaware 19977 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Graves Chapel Cem. | 06/01/2002 | Millington, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | Bennie Smith Funeral Home Road 298, Chestertown, Maryland 21620 |

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Dehydration | 2 wks. |
| Due to (or as a consequence of): | b. Dementia, Alzheimer's type | 2 yrs. |
| Due to (or as a consequence of): | c. Chronic cholecystitis | 6 mo. |
| Due to (or as a consequence of): | d. Rectal bleeding | 3 wks. |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

BPH, severe arthritis, chronic Renal failure

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and Title of Certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D51735 | 5/28/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Delboy, 6620 Church Hill Rd., Chestertown, Maryland 21620

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 31 2002 | Bennie G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18774

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Goldie | Johnson | May 23 2002 | 8:30PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 22051 Marsh Creek road | Preston | Caroline |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-05 0272 | 1 M 2 F | 95 Yrs. | | | Nov.20,1906 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Caroline | Preston | 1 Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 22501 Marsh Creek Road | 21655 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 No | 1 Yes 2 No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Homemaker | some one else's home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Guy Patterson | Leona Black |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Paul L. Holmes,Jr./Grandson | 22051 Marsh Creek Road, Preston,Maryland 21655 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Mt.Pleasant Cemetery | 5/27/2002 | Preston,Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | Bennie Smith Funeral Home 426 Dover Street, Easton,Maryland 21601 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive Heart Failure | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

Hypertension

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| James Sides MD | D31376 | 5/28/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James Sides 920 Market St Denton MD 21629

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | Penny B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18775

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): FLORENCE JACOBS
2. Date of Death: Month: May; Day: 24; Year: 2002
3. Time of Death: 0925
4a. Facility Name (If not institution, give street end number): Chesapeake Hospice House
4b. City, Town, or Location of Death: Linthicum
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 227-46-0117
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Jan. 1, 1935
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5008 Decatur Street
10f. Zip Code: 20781
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printing & Engraving Bureau
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): James Pratt, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Beatrice L. Pendleton

19a. Informant's Name/Relationship (Type, Print): Stephen W. Hayes - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5008 Decatur St. Hyattsville, MD 20781

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sunset Memorial Gardens
Date: 5/31/02
20c. Location - City or Town, State: Fredericksburg, VA

21. Signature of Funeral Service Licensee: Allen W. Woodell
22. Name and Address of Facility: Bailey Funeral Service, 1207 White St Fredericksburg, VA

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset end Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pancreatic Cancer | 3 months |
| | Due to (or as a consequence of): Multiple Myeloma | 6 months |
| Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as e consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Stephen Stall MD
29c. License number: D18219
29d. Date signed (Month, Dey, Yeer): May 24, 2002

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Stephen Stall, MD 1221 Mercantile Lane Largo, MD

**State Registrar**

31. Dete filed (Month, Day, Year): MAY 31 2002
32. Registrer's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Amend Item 9 per F.D. 05/28/2002 Carroll County, wjl

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18776

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| MARY EUGENE KAUFFMAN | MAY 27, 2002 | 9:15 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2613 SANDYMOUNT RD. | FINKSBURG | CARROLL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 294-44-2092 | 1☐M 2☒F | 85 Yrs. | | | 7/22/1916 | INDIANA ~~INDINIA~~ |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | CARROLL | FINKSBURG | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2613 SANDYMOUNT RD. | 21048 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | HOUSEWIFE | HOMEMAKER |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CHARLES GIBBENS | Clara F. Fraley |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| BRENDA J. DELL -DAUGHTER | 2613 SANDYMOUNT RD., FINKSBURG, MD. 21048 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify) | FAIRVIEW CEMETERY | 5/31/02 | WEST LIBERTY, OHIO |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | FLETCHER FUNERAL HOME 254 E. MAIN ST.,WESTMINSTER, MD. 21157 |

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ASCVD | 25 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): advanced age | 85 yrs |
| | c. Due to (or as a consequence of): Dementia | 10 yrs |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

| 29a. Certifier (Check only one) | |
|---|---|
| 1☒ | **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
| 2☐ | **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ John W. Middleton MD | D25443 | 5-28-2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John W. Middleton 688 Poole Road, Westminster, Md 21157

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

WJL 4

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18777

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Kathleen Kesler
2. Date of Death (Month, Day, Year): May 26th 2002
3. Time of Death: 01:20 AM
4a. Facility Name (If not institution, give street and number): University of Maryland at Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 212-46-8146
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 55 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 24 1946
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2 Marbeth Hill
10f. Zip Code: 21157
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Special Ed Teacher
16b. Kind of Business/Industry: Carrolltowne Elem

17. Father's Name (First, Middle, Last): Clarence E. Buck
18. Mother's Name (First, Middle, Maiden Surname): Naomi L. Schmiedicke

19a. Informant's Name/Relationship (Type, Print): Karen Straehley / POA
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1396 Alison Court Westminster, MD 21158

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Wesley Freedom Church Cem
Date: 5/30/2002
20c. Location - City or Town, State: Eldersburg, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD 21157

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Multiple Myeloma

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sungyk Jang
29c. License number: P13881
29d. Date signed (Month, Day, Year): May 26th 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sungyk Jang, MD 22 S. Greene St. Baltimore MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJR 14

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18778

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EUNICE DAVIS KRIEG

2. Date of Death Month Day Year: MAY 22, 2002

3. Time of Death: 8:55 pM

4a. Facility Name (If not institution, give street and number): 1903 Cevil Ave.

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 217-18-2450

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 15,1922

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1903 Cevil Ave.

10f. Zip Code: 21804

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): –

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: E.I.DuPont

17. Father's Name (First, Middle, Last): Paul Theophilus Davis

18. Mother's Name (First, Middle, Maiden Surname): Susie Robenia Houghton

19a. Informant's Name/Relationship (Type, Print): Francis J. Krieg Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1903 Cevil Ave., Salisbury, MD 21804

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory

Date: 5/23/02

20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC OVARIAN CARCINOMA — Approximate Interval Between Onset and Death: 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] KUMAR RAJAGOPALAN

29c. License number: D0051806

29d. Date signed (Month, Day, Year): 05/23/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kumar Rajagopalan, M.D. 145 E. Carroll St, A-1 Salisbury, MD 21801

**State Registrar**

31. Date filed (Month, Day, Year): MAY 24 2002

32. Registrar's Signature: [signature]

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5MP

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No 2002 18779

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ivory V. Keller

2. Dete of Deeth: Month June Dey 1 Year 2002

3. Time of Death: 05-35

4a Facility Neme *(If not institution, give street and number)*: Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Deeth: Cecil

**Funeral Director**

5. Social Security Number: 219-18-5114

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: Jan. 24, 1923

9. Birthplace *(State or Foreign Country)*: Virginia

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Cecil

10c. City, Town or Location: Port Deposit

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1583 Tome Highway

10f. Zip Code: 21904

10g. Citizen of Whet Country?: USA

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeper

16b. Kind of Business/Industry: Government

17. Father's Neme *(First, Middle, Last)*: Charles Adams

18. Mother's Name *(First, Middle, Maiden Surname)*: Rettie M. Powers

19a. Informant's Name/Relationship *(Type, Print)*: Mary Thomas/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1583 Tome Hwy., Port Deposit, MD 21904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: New Bridge Cemetery

Date: 6-3-2002

20c. Location - City or Town, State: Rising Sun, Maryland

21. Signature of Funeral Service Licensee: Richard L. Goodie

22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. ATRIAL FIBRILLATION

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

RENAL FAILURE

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*: N/A

28b. Time of Injury: N/A M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: N/A

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: N/A

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Rodney Donham

29c. License number: H0058419

29d. Date signed *(Month, Day, Year)*: 06/02/2002

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): RODNEY DONHAM, D.O. 106 BOW STREET ELKTON, MD 21921

**State Registrar**

31. Date filed *(Month, Day, Year)*: JUN 03 2002

32. Registrer's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

5

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18780

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| THECLA | ESTELLE | KRAMER | MAY 25, 2002 | 11:39 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| MONTGOMERY GENERAL HOSPITAL | OLNEY | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 463-26-3159 | 1☐M 2☒F | 76 Yrs. | | | Nov.19, 1925 | Texas |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Montgomery | Sandy Spring | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 17310 Quaker Lane, C-23 | 20860 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | Property Manager | Rental Apartments |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Henry Grapperhaus | Marie Mossinghoff |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Thecla D. Meyer / Daughter | 3 Porter Court, Ashton, Maryland 20861 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metropolitan Crem. | 5/29/02 | Alexandria, Virginia |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Muriel H. Barber | Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. cardio pulmonary arrest | 20 minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Asystole | 20 minutes |
| | c. Due to (or as a consequence of): hypertension | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Depression
Anorexia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M.D. | D52481 | May 27, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David Plotkin M.D. 18111 Prince Philip Drive Suite 304 Olney Maryland 20832

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | ▶ Geneva G. Sparks |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18781

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Steven Kostic

2. Date of Death: Month May Day 25, Year 2002

3. Time of Death: 2120 M

4a. Facility Name (If not institution, give street and number): Montgomery Hospice Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 200-20-6221

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 22, 1928

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: California

10b. County: Los Angeles

10c. City, Town or Location: Beverly Hills

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 356 South Linden Drive

10f. Zip Code: 90212

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean Conflict

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Operative

16b. Kind of Business/Industry: Central Intelligence Agency

17. Father's Name (First, Middle, Last): John Kostic

18. Mother's Name (First, Middle, Maiden Surname): Anna Chutko

19a. Informant's Name/Relationship (Type, Print): Camilla C. Kostic/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 356 South Linden Drive, Beverly Hills, CA 90212

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: May 30, 2002

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: David E. Perry M00803

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: Years

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Sclerosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chitra Rajagopal

29c. License number: D42452

29d. Date signed (Month, Day, Year): May 25, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chitra Rajagopal, M.D. 18111 Prince Phillip Drive, #327, Olney, Maryland 20832

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002

32. Registrar's Signature: Jennie G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6+1

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND #29d, 5/31/2002, BMW, MCCo

# Certificate of Death

Reg. No. 2002 18782

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JANE ELIZABETH KINSEY
2. Dete of Death: Month MAY Dey 27 Year 2002
3. Time of Death: 1:05 PM
4e Feciity Name (If not institution, give street end number): WILSON HEALTH CARE CENTER
4b. City, Town, or Location of Death: GAITHERSBURG
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 219-46-7270
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Sept.1, 1907
9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Md.
10b. County: Frederick
10c. City, Town or Location: Monrovia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 12121 Gladhill Brothers Road
10f. Zip Code: 21770
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Lest): Clarence Lee Ayton
18. Mother's Name (First, Middle, Maiden Surname): Eva Dutrow

19a. Informant's Name/Relationship (Type, Print): Edwin R. Kinsey, Jr. / Son
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 12121 Gladhill Brothers Rd., Monrovia, Md. 21770

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 5/29/02
20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: Muriel H. Barber
22. Name and Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Md. 20882

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Ceuse (Final disease or condition resulting in death) a. | pulmonary edema | 4 hours |
| Due to (or es a consequence of): b. | myocardial infarction | 1 day |
| Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: John R. Melnick MD
29c. License number: D 19294
29d. Date signed (Month, Day, Year): May 27, 2002

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): JOHN R. MELNICK 911 RUSSELL AVE GAITHERSBURG, Md. 20879

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrer's Signature: Donna B. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18783

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Dorothy Evelyn Kerns | May 24 2002 | 20:49 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington Adventist Hospital | Takoma Park | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578-12-6349 | 1☐M 2☒F | 83 Yrs. | | | Dec 26, 1918 | DC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Silver Spring | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15910 Woodscenter Road | 20906 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Unknown Mundy | Laura May Mundy |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| George W. Kerns / Husband | 15910 Woodscenter Road, Silver Spring, MD 20906 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Parklawn Memorial Park | May 29, 2002 | Rockville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Robert C Ramsey | Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR RUPTURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. ATHEROSCLEROTIC CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month / Day / Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | d 23145 | May 24, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ngozika Nwaneri 7214 Kempton Road, Lanham, MD 20706

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** MEM

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18784

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): REGINALD T. LEWIS
2. Date of Death (Month, Day, Year): MAY 28 2002
3. Time of Death: 1705
4a. Facility Name (If not institution, give street and number): UNION HOSPITAL
4b. City, Town, or Location of Death: ELKTON
4c. County of Death: CECIL

**Funeral Director**

5. Social Security Number: 219-20-9475
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 15, 1926
9. Birthplace (State or Foreign Country): MD.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD.
10b. County: CECIL
10c. City, Town or Location: ELKTON
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 370 W. LEWIS SHORE ROAD
10f. Zip Code: 21921
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII NAVY 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNED + OPERATED ELKTON TRUCKING
16b. Kind of Business/Industry: TRUCKING

17. Father's Name (First, Middle, Last): EDWARD F. LEWIS
18. Mother's Name (First, Middle, Maiden Surname): JULIA LAWS

19a. Informant's Name/Relationship (Type, Print): DORIS LEWIS - WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 370 W. LEWIS SHORE ROAD ELKTON MD. 21921

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bethel Cemetery | Date: May 31, 2002
20c. Location - City or Town, State: Chesapeake City, MD.
21. Signature of Funeral Service Licensee: Edward McKown
22. Name and Address of Facility: Gee Funeral Home 259 E. MAIN ST ELKTON MD. 21921

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 1 day |
| Due to (or as a consequence of): | b. Lung carcinoma | 6 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Sepsis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D0056698
29d. Date signed (Month, Day, Year): MAY 29, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACINTO P. CASIO MD 1100 LOVERING AVE. SUITE 10-C WILMINGTON, DE 19806

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SEP

25 + 1 VA

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18785

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| IDA B. LONG | MAY 29, 2002 | 11:15 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 5410 Tuscarawas Road | Bethesda | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 086-03-6785 | 1☐ M 2☒ F | 91 Yrs. | | | Feb. 19,1911 | Connecticut |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Montgomery | Bethesda | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5410 Tuscarawas Road | 20816 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Dietician | Bedford Central Schools |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Antonio Buffoni | Maria Pampaluna |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Virginia Murphy (Daughter) | 5410 Tuscarawas Rd., Bethesda, MD 20816 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Metro Funeral Srv | 5/29/01 | Alexandria, VA |

21. Signature of Funeral Service Licensee: George R Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Alzheimers Disease | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

On hospice care
Unable to eat

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D33138

29d. Date signed (Month, Day, Year): 5/29/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daniel Jaller, M.D. 19500 Amaranth Dr., Suite B, Germantown, MD 20878

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18786

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Paul F. Lewis | May 25, 2002 | 8:51 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington Adventist Hospital | Takoma Park | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578-22-5524 | 1☒M 2☐F | 75 Yrs. | | | May 8, 1927 | Washington, DC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Montgomery | Silver Spring | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9505 New Hampshire Ave. | 20903 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1946-1947 | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Property Marketing Specialist | U.S. Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Daniel M. Lewis | Cornelia F. Ford |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Katherine A. Lewis/ Wife | 9505 New Hampshire Ave., Silver Spring, MD 20903 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Maryland Nat. Mem. Pk. | May 30, 2002 | Laurel, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Degeneration

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hyperlipidemia

Due to (or as a consequence of):

c. Cardiac Arrest

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D35826 | May 28, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Horacio Schapiro, 7600 Carroll Ave, Takoma Park, MD 20912

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | ▶ G. Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18787

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| IRENE MCLAREN | May 22nd 02 | 655 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Northwest Hospital Center | Randallstown | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-20-7471 | 1☐M 2☒F | 82 Yrs. | | | May 6, 1920 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Marriottsville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3839 Wards Chapel Road | 21104 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Homemaker | Domestic |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Frank | Carie Claggett |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Irene New (Daughter) | 6600 Gigi Drive Woodbine, MD 21794 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Lake View Mem. Park | 5/28/02 | Sykesville, MD |

21. Signature of Funeral Service Licensee: ▶ Brian L. Haight

22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Chronic Obstructive Pulmonary

Due to (or as a consequence of):
c. Disease

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Joginder P Mehta M.D | D0041410 | May 22nd, 2002. |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P MEHTA, 5401 OLD COURT ROAD NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WSF 5+3

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18788

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Pamela Mitchell
2. Date of Death: Month May Day 23 Year 2002
3. Time of Death: 1632 M
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

**Funeral Director**

5. Social Security Number: 213-84-7933
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 41 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 30 1961
9. Birthplace (State or Foreign Country): TN

Usual Residence of Decedent

10a. State: Md
10b. County: Prince Georges
10c. City, Town or Location: Berwyn Heights
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6102 Ruatan Street
10f. Zip Code: 20740
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): secretary
16b. Kind of Business/Industry: clerical

17. Father's Name (First, Middle, Last): Cyril Mitchell
18. Mother's Name (First, Middle, Maiden Surname): Jane Gallagher

19a. Informant's Name/Relationship (Type, Print): Perry Mitchell (brother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8506 Paxton Ct. Berwyn Heights, Md 20740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cem.
Date: 5-25-02
20c. Location - City or Town, State: Adelphia, Md

21. Signature of Funeral Service Licensee: ▶ Paige Haught Herbert
22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — 4days
Due to (or as a consequence of):
b. Liver Failure — 5months
Due to (or as a consequence of):
c. Budd Chiari Syndrome — 5months
Due to (or as a consequence of):
d. Polycythemia Vera — 5months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Cynthia De Ruiter, Medical Doctor
29c. License number: Res-000
29d. Date signed (Month, Day, Year): MAY 23 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cynthia De Ruiter The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: ▶ Penny G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WSL 2

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18789

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Clara Mae Moore | May 16 2002 | 11:02 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Wicomico Nursing Home | Salisbury | Wicomico |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 086-50-2093 | 1☐ M 2☒ F | 92 Yrs. | | | Dec 24, 1909 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Wicomico | Fruitland | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 220 Dulaney Avenue | 21826 | U.S. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8th | | Domestic | Private Families |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Oliver Collier, Sr. | Rena Belle Jones |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Oliver Collier, Jr./brother | 219 Dulaney Avenue, Fruitland, MD 21826 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Springhill Memory | 5/22/2002 | Salisbury, MD |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
Lewis N. Watson Funeral Home
1618 West Rd., Salisbury, MD 21801

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. HEMORRHAGIC CVA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D55006 | MAY 17, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mohan Bhat MD 614 Easternshore Drive Salisbury MD 21804

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 22 2002 | ▶ [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18790

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DORETHA MCNEIL

2. Date of Death: Month MAY Day 16 Year 2002

3. Time of Death: 3:10 PM

4a. Facility Name (If not institution, give street and number): DEERS HEAD HOSPITAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 245-50-7408

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 5, 1929

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10218 Old Ocean City Blvd., Apt. 803

10f. Zip Code: 21811

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): James H. Gaddy

18. Mother's Name (First, Middle, Maiden Surname): Julia Thompson

19a. Informant's Name/Relationship (Type, Print): Shirelle McNeil/granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 1245, Berlin, MD 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Paul's Cemetery

Date: 5/22/02

20c. Location - City or Town, State: Berlin, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. END STAGE RENAL DISEASE | 1+ yr |
| Due to (or as e consequence of): | b. DIABETES MELLITUS - 2 | 10+ yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

26. Place of Death (Check only one) Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

22e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Virginia A. Dulany MD

29c. License number: D 33905

29d. Date signed (Month, Day, Year): MAY 16, 2002

30. Name and address of person who completed cause of death (Item 23) (Type, Print): VIRGINIA A DULANY M.D. PO Box 2018 SALISBURY Md 21802

**State Registrar**

31. Date filed (Month, Day, Year): MAY 22 2002

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "netural', or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4 DQ

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2002 18791

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Graybil Leroy Myers | May 28 2002 | 1:32 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Montgomery General Hospital | Olney | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 176-10-1521 | XX M 2☐ F | 78 Yrs. | | | Nov 17 1923 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Montgomery | Silver Spring | 1☐ Yes 2☐ No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15310 Pine Orchard Drive, Unit 1A | 20906 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | unemployed | not applicable |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Graybil R Myers | Margaret Schubert |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Violet Morton/step-mother | 15310 Pine Orchard Dr Unit 1A, Silver Spring MD 20906 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify) | Morningside Cemetery | May 31 2002 | DuBois, Pennsylvania |

21. Signature of Funeral Service Licensee: ▶ Laura Sanda

22. Name and Address of Facility: Hines Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave Silver Spring MD 20904

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE MYOCARDIAL INFARCTION | 1 HOUR |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D 24543 | MAY 28, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES ROSSI 3305 N. LEISURE WORLD BLVD. SILVER SPRING MD 20906

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | Jeanne B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18792

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROBERT UPTON MUSGROVE
2. Date of Death (Month, Day, Year): MAY 23, 2002
3. Time of Death: 5:18 AM
4a. Facility Name (If not institution, give street and number): 7517 LAYTONIA DRIVE
4b. City, Town, or Location of Death: GAITHERSBURG
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 220-40-7128
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 59 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.18, 1942
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7517 Laytonia Drive
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Driver
16b. Kind of Business/Industry: Nursing Home

17. Father's Name (First, Middle, Last): Robert Stephen Musgrove
18. Mother's Name (First, Middle, Maiden Surname): Virgie Ethel Teeter

19a. Informant's Name/Relationship (Type, Print): Karen Sue Hildebrand/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 616½ Wilson Place, Frederick, Md. 21702

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 5/23/02
20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: Muriel H. Barber
22. Name and Address of Facility: Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute myocardial infarction — Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hyperlipidemia
Chronic obstructive pulmonary disease
Spinal stenosis

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Robert Birschbach MD
29c. License number: D04115
29d. Date signed (Month, Day, Year): MAY 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. ROBERT BIRSCHBACH MD 201 Russell Avenue Gaithersburg MD 20877

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18793

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Anna B. Mohnacky

2. Date of Death: Month May, Day 24, Year 2002

3. Time of Death: 7:15 PM

4a. Facility Name (If not institution, give street and number): Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 178-07-2320

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 98 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7/2/1903

9. Birthplace (State or Foreign Country): MA

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11215 Oak Leaf Drive, #410

10f. Zip Code: 20901

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeping

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Joseph Daniels

18. Mother's Name (First, Middle, Maiden Surname): Barbara Unknown

19a. Informant's Name/Relationship (Type, Print): Anna Louise Phillips/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11215 Oak Leaf Drive, #410, Silver Spring, MD 20901

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 5/26/2002

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Robert A Degnan

22. Name and Address of Facility: Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease — Approximate Interval Between Onset and Death: Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice House

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chitra Rajagopal

29c. License number: D42452

29d. Date signed (Month, Day, Year): May 25, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Chitra Rajagopal 18111 Prince Phillip Dr. #327 Olney, MD 20832

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature: Geneva G. Scarlett

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18794

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Jane Miller

2. Date of Death: Month May Day 24, Year 2002

3. Time of Death: 1:35 AM

4a. Facility Name (If not institution, give street and number): 15217 Baileys Lane

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 127-26-5783

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 28, 1933

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14311 Arctic Avenue

10f. Zip Code: 20853

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Grants Administrator

16b. Kind of Business/Industry: National Institutes of Health

17. Father's Name (First, Middle, Last): Peter Blaner

18. Mother's Name (First, Middle, Maiden Surname): Mary Rohal

19a. Informant's Name/Relationship (Type, Print): Susan J. Rubbo/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15217 Baileys Lane, Silver Spring, Maryland 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: May 29, 2002

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: William A. Pumphrey M01173

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home, Rockville, Inc., 300 W. Montgomery Avenue, Rockville, MD 20850

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of the Renal Pelvis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) daughter's residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Hawkins

29c. License number: DC MD 19757

29d. Date signed (Month, Day, Year): 5/24/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Hawkins, M.D. 110 Irving St., N.W., Washington, D.C. 20010-2975

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature: Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND #8,5/30/2002,EMW,MoCo

# Certificate of Death

Reg. No. 2002 18795

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Benjamin Franklin McNeal

2. Date of Death (Month, Day, Year): May 23, 2002

3. Time of Death: 9:56 P. M

4a. Facility Name (If not institution, give street and number): Casey House Hospice

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 067-30-3662

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~May~~ March 19, 1917

9. Birthplace (State or Foreign Country): Mississippi

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 419 Russell Avenue #519

10f. Zip Code: 20877

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Psychologist

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Benjamin Franklin McNeal Sr.

18. Mother's Name (First, Middle, Maiden Surname): Pearl Mosely

19a. Informant's Name/Relationship (Type, Print): Leslie Barden/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7101 Garmon Road Bethesda, MD 20817

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Geo. Wash. University Medical Center

Date: May 23 2002

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Columbia Mortuary Services, Inc. P.O. box 58007 Washington, D.C. 20037

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer — 2 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cidificile Colitis

Cerebro-Vascular Accident

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD Staff Physician

29c. License number: D0041218

29d. Date signed (Month, Day, Year): 5/24/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cheryl Aylesworth, m.d. 6001 Muncaster Mill Rd. Rockville, MD 20855

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: [signature] G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18796

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Matilde G. Martinez
2. Date of Death (Month, Day, Year): May 30, 2002
3. Time of Death: 3:32 P M
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-54-8407
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 26, 1920
9. Birthplace (State or Foreign Country): Cuba

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 18705 Thornberry Lane
10f. Zip Code: 20832
10g. Citizen of What Country?: Cuba

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☒ Yes 2☐ No Specify: Cuban
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Plutarco Diaz
18. Mother's Name (First, Middle, Maiden Surname): Genara Rodriguez

19a. Informant's Name/Relationship (Type, Print): Ray Martinez / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18701 Thornberry Lane, Olney, MD 20832

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: June 1, 2002
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: John E. Gale
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Acute Myocardial Infarction | 72 hours |
| Due to (or as a consequence of): b. | Coronary Artery Disease | 72 hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Hypercholesterolemia | 30 years |
| Due to (or as a consequence of): d. | | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard Weinstein, MD
29c. License number: D42777
29d. Date signed (Month, Day, Year): May 30, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Weinstein, MD 18111 Prince Philip Drive Olney, MD 20832

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

10

**To be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18797

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Florence B. Marzulli | May 26, 2002 | 6:15 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Shady Grove Adventist Hospital | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 553-12-8119 | 1☐M 2☒F | 84 Yrs. | | | May 27, 1917 | California |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Bethesda | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8044 Park Overlook Drive | 20817 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| – | 5+ | Teacher | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Bushelman | Florence Lee Tower |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Francis N. Marzulli/ Husband | 8044 Park Overlook Drive, Bethesda, Maryland 20817 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Montgomery Crematorium, Inc. | May 29, 2002 | Bethesda, Maryland |

21. Signature of Funeral Service Licensee: M00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiopulmonary Arrest | Acute |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Renal Failure | Chronic |
| | Due to (or as a consequence of): | |
| | c. Lymphoma | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| John Wallmark M.D. | 53177 | May 26, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Wallmark, M.D. 9707 Medical Center Drive, Rockville, Maryland 20850

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | Jenna G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18798

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Cornelia McCoy Marshall | May 27, 2002 | 11:20 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Montgomery General Hospital | Olney | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 098-26-5250 | 1☐M 2☒F | 97 Yrs. | | | Jan 15, 1905 | Ohio |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Silver Spring | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3701 International Drive, #561 | 20906 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5 + | Religious Education Director | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Perry Smith | Juliet Kane McCoy |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Juliet Mofford / Daughter | 95 Elm Street, Andover, MA 01810 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metropolitan Crematory | May 29, 2002 | Alexandria, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Ken R. Thomas. | Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Congestive Heart Failure | 24 hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Septicemia | 24 hours |
| | c. Due to (or as a consequence of): Urinary Tract Infection | 48 hours |
| | d. Due to (or as a consequence of): | |

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ O.J. Lawless | D 25410 | May 28 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.J. LAWLESS 18111 Prince Philip Drive Olney MD.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | ▶ Geneva G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18799

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Agya Kaur Maker
2. Date of Death (Month Day Year): May 25, 2002
3. Time of Death: 2:09A M
4a. Facility Name (If not institution, give street and number): 10201 Norton Road
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 220-98-7479
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 16, 1919
9. Birthplace (State or Foreign Country): Pakistan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 10201 Norton Road
10f. Zip Code: 20854
10g. Citizen of What Country?: India

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian Indian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arjan Singh
18. Mother's Name (First, Middle, Maiden Surname): Ram Kaur

19a. Informant's Name/Relationship (Type, Print): Ujjal S. Maker/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25 Laurel Drive, Mechanicsburg, PA 17055

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: May 26, 2002
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: David E. Perry. M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Septic Shock — 24 Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Acute Cerebrovascular Accident

Due to (or as a consequence of):
c. Acute Pulmonary Embolism

Due to (or as a consequence of):
d. Acute Myocardial Infarction

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hilmo. Khaney
29c. License number: D22978
29d. Date signed (Month, Day, Year): May 25, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. Khiney, M.D. 19520 Doctors Drive, Germantown, Maryland 20874

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: Jennie G. Smith

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

02-2726-041
mnmr
Thomas Madison

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061202: ITEMS#23a,27 per ME G808 ss

# Certificate of Death

Reg. No. 2002 18800

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thomas Bryant Madison
2. Date of Death Month: May Day: 26, Year: 2002
3. Time of Death: 9:54 a M
4a. Facility Name (If not institution, give street and number): Easton Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 214-32-1005
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 04, 1934
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Caroline
10c. City, Town or Location: Denton
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 709 Gay Street
10f. Zip Code: 21629
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Trucking Company

17. Father's Name (First, Middle, Last): William Bryant Madison
18. Mother's Name (First, Middle, Maiden Surname): Beatrice Wise

19a. Informant's Name/Relationship (Type, Print): Eloise Madison
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 709 Gay Street Denton, Maryland 21629

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Spring Grove Cemetery
Date: 6/01/02
20c. Location - City or Town, State: Denton, Maryland

21. Signature of Funeral Service Licensee: Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St. Cambridge, Maryland 21613

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): May 27, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospitel or Attanding Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18801

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Harold Irwin Nesbitt | May 26 2002 | 12:20A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 711 Harrisville Road | Colora | Cecil |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-30-3671 | 1 ☒ M 2 ☐ F | 83 Yrs. | | | July 1, 1918 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Cecil | Colora | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 711 Harrisville Road | 21917 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | farmer | agriculture |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Sterling Nesbitt | Anna Mary Irwin |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ann Nesbitt/wife | 711 Harrisville Road, Colora, MD 21917 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Brookview Cemetery | May 29, 2002 | Rising Sun, MD |

21. Signature of Funeral Service Licensee: Frank C. McFall

22. Name and Address of Facility: R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC CANCER. | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Thomas A. Biondo MD | D42800 | 5/28/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. A. Biondo MD 3195 Union Blvd, Ste 4D6, Md, 21078

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | Brenda D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18802

WILBERT TYRONE OLIVER
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILBERT TYRONE OLIVER
2. Date of Death: Month May, Day 22, Year 2002
3. Time of Death: 9:15 PM
4a. Facility Name (If not institution, give street and number): Salisbury Rehab & Nursin Center
4b. City, Town, or Location of Death: Salisbury, Md
4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 220-74-8432
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 43 Yrs. — If Under 1 Year: Months, Days; If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 7-5-58
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County: SOMERSET
10c. City, Town or Location: PRINCESS ANNE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 30829 ~ HAMPDEN AVE.
10f. Zip Code: 21853
10g. Citizen of What Country?: USA

**To Be Completed by Funeral Director**

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): UNK; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MASONRY
16b. Kind of Business/Industry: MERRILL CONSTRUCTION

17. Father's Name (First, Middle, Last): JAMES BARNES
18. Mother's Name (First, Middle, Maiden Surname): MARY OLIVER MARTIN

19a. Informant's Name/Relationship (Type, Print): JOYCE PALMER ~ FRIEND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30829 - HAMPDEN AVE, PRINCESS ANNE, MD, 21853

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CAPITOL CREMATORY
Date: 5/30/02
20c. Location - City or Town, State: DOVER, DE.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: BENNIE SMITH F/H 917-W. ISABELLA ST. SALISBURY, MD. 21801

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. AIDS
Approximate Interval Between Onset and Death: years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D-29349
29d. Date signed (Month, Day, Year): 5/23/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM ROBINS, MD., 1104 HEALTHWAY DR., SALISBURY, MD 21804

**State Registrar**

31. Date filed (Month, Day, Year): MAY 24 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18803

**Physician /Medical Examiner**

1. Decedent's Nama (First, Middle, Last): Pedro Ortiz

2. Date of Death Month May Day 26 Yaar 2002

3. Tima of Death: 7:20AM

4a Facility Nama (If not institution, giva street and number): Kent and Queen Annes Hospital

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

**Funeral Director**

5. Social Security Numbar: 582-44-4360

6. Sax 1☒M 2☐F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): April 27,1938

9. Birthplaca (Stata or Foreign Country): Puerto Rico

Usual Residance of Decedant

10a. Stata: Maryland

10b. County: Kent

10c. City, Town or Location: Millington

10d. Inside City Limits 1☐Yas 2☒No

10e. Street and Number: 10520 Chesterville Forest Road

10f. Zip Code: 21651

10g. Citizen of What Country? USA

11. Marital Status 1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yes, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☒Yas 2☐No Specify: Puerto Rican

14. Race - Amarican Indian, Black, Whita, atc. Specify: Puerto Rican

15. Decedant's Education (Specify only highast grade compiatad): Elementary/Secondary (0-12): 9 College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): Cabinet Maker

16b. Kind of Businass/Industry: Shultz Mobile Homes

17. Father's Nema (First, Middla, Last): Francisco Ortiz

18. Mothar's Nama (First, Middle, Maidan Sumama): Irenes Burgos

19a. Informant's Name/Relationship (Type, Print): Bessie Ortiz / Wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 10520 Chesterville Forest Rd., Millington,Md.21651

20a. Method of Disposition 1☒Burial 2☐Cramation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Male & Female Beneficial Cemetery

Date: 05/30/02

20c. Location - City or Town, Stata: Chestertown,Maryland

21. Signature of Funaral Service Licensaa: [signature]

22. Nama and Addrass of Facility: Bennie Smith Funeral Home Road 298 , Chestertown,Maryland 21620

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after daath with tha Maryland Department of Health and Mantal Hygiana.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Entar tha disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximata Intarval Batwaan Onset and Daath

Immediata Cause (Final diseasa or condition resulting in death)

a. CARDIOpulmonary ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypotension

Dua to (or as a consequance of):

c. Dehydration

Dua to (or as a consequance of):

d. Sepsis

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.

CHRONIC Renal Failure

23b. Did tobacco usa contributa to the causa of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requiras that tha daath cartificata be axacutad within 24 hours after daath.

To the Funaral Director: Aftar this certificate has baan signed by tha attanding physician and completely filled in by the funaral director, paga 2 should ba datachad for use as tha burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Othar (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28f. Location (Streat and Number or Rural Routa Numbar, City or Town, Stata)

29a. Cartifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha time, data and place, and dua to tha causa(s) and mannar as statad.

2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, death occurred at tha time, data end place, and due to tha causa(s) and mannar statad.

29b. Signatura and titla of certifiar: J. C. Arkabar Jr. M.D

29c. Licansa number: D23889

29d. Data signad (Month, Day, Yaar): 5/28/02

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): John C. Arkabar JR, M.D. 223 High Street, Chestertown, Md 21620

**State Registrar**

31. Data filed (Month, Day, Year): MAY 31 2002

32. Registrar's Signatura: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18804

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: CHARLOTTE D. OWENS
2. Dete of Deeth: Month May; Dey 24; Year 2002
3. Time of Death: 4:20 AM
4a. Fecility Neme *(If not institution, give street end number)*: Genesis ElderCare - The Pines
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 220-05-5643
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs.
If Under 1 Year: Months; Days
If Under 24 Hrs.: Hours; Min.
8. Dale of Birth *(Month, Day, Yeer)*: JUN 29 1916
9. Birthplace *(State or Foreign Country)*: PA

Usuel Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 700 PORT ST., APT 131
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SECRETARY
16b. Kind of Business/Industry: FEDERAL AVIATION AGENCY

17. Father's Name *(First, Middle, Last)*: PAUL A. DAVIS
18. Mother's Name *(First, Middle, Maiden Surname)*: IMOGENE HARR

19a. Informant's Name/Relationship *(Type, Print)*: ONCKEN OWENS, JR./HUSBAND
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 700 PORT ST., APT 131, EASTON, MD 21601

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHESAPEAKE CREMATION CTR
Date: 5-24-02
20c. Locelion - Cily or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: JOHN R. MERCER
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia — days

Due to (or as e consequence of):
b. Chronic debility — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Lest
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Spinal stenosis

23b. **Did tobacco uee contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, slreel, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signafure and title of certifier
29c. License number: D25933
29d. Date signed *(Month, Dey, Year)*: 5.24.02
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): MICHAEL CROWLEY, MD 508 IDLEWILD AVENUE EASTON, MD 21601

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 28 2002
32. Registrer's Signature: Donna B. Harris

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter death.
To the Funeral Director: After this certificete hes been signed by the etending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Charlotte Owens

DB3

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18805

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| CHARLES L. O'NEILL | MAY 26 2002 | 1229 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| MONTGOMERY GENERAL HOSPITAL | OLNEY | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 503-28-4058 | X 1 M 2 F | 66 Yrs. | | | Nov 21, 1935 | South Dakota |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Silver Spring | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15100 Interlachen Drive, #1025 | 20906 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Insurance Executive | Insurance |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles M. O'Neill | Cora Osborne |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 |
|---|---|
| Patricia O'Neill / Wife | 15100 Interlachen Drive, #1025, Silver Spring, MD |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Gate of Heaven Cemetery | May 31, 2002 | Silver Spring, MD |

21. Signature of Funeral Service Licensee: Andrew J. Cole

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ANOXIC ENCEPHALOPATHY | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. FOOD ASPIRATION | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 Yes 2 No 3 Probably 4 X Unknown | 1 Yes 2 X No | 1 Yes 2 X No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 No | Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 Natural 2 X Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | 5/25/02 | N 1800 M | 1 Yes 2 X No | CHOKED ON FOOD AT DINNER |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| NURSING HOME | 18131 SLIGO SCHOOL RD SANDY SPRINGS, MD |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| M.D. (ONE) | 015236 | 5/29/2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL E. MARGOLIS, MD 11125 ROCKVILLE PIKE, ROCKVILLE MD 20852

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | Geneva B. Sparks |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 3

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18806

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JUNE MARIE POAGE | MAY 23, 2002 | 3:40 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| CARROLL COUNTY GENERAL HOSPITAL | WESTMINSTER | CARROLL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 142-30-2961 | 1☐M 2☒F | 63 Yrs. | | | 6/21/1938 | PENNSYLVANIA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | CARROLL | WESTMINSTER | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 804 WINCHESTER DR. | 21157 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | MANAGER | AIRPORT |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOSEPH O. HOFFMAN | VIOLA MAY MacNEIL |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOSEPH O. HOFFMAN -BROTHER | 311 BEACH DR., CAPE MAY, N.J. 08204 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | KRIDER'S CEMETERY | 5/26/02 | WESTMINSTER, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Lymphoma | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Seizure

Respiratory failure - acute

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☑No 3☐Probably 4☐Unknown | 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Howard Saintz, M.D. | Md. # D15552 | 5/24/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Saintz, M.D. 555 S. Center St. Westminster, Md. 21157

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ Geneva G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JUNE MARIE POAGE

WJR 10

DHMH 1-7 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18807

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Anita Amelia Petry | May 24 2002 | 3:50 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 30 Locust St. Apt. 415 | Westminster | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-28-3522 | 1☐M 2☒F | 69 Yrs. | | | June 26, 1932 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Carroll | Westminster | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 30 Locust St. Apt. 415 | 21157 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John H. Roberts | Anita Lessner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Kathleen Mathias/Daughter | 1523 Teal Dr., Ocean City, MD 21842 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Trinity UCC Church Cem | 05/28 2002 | Manchester, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | Pritts Funeral Home & Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Hypertensive Cardiovascular Disease | 8 years |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Adult onset Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| D.V. Faustino M.D. | D12901 | 5/28/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
D.V. FAUSTINO, M.D. 4111 Lower Beckleysville Rd. Hampstead, MD 21074

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | Geneva G Sparks |

DHMH 17 Rev 1/2001

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Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJR 5

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18808

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| CHARLES MALCOLM PURDUM | MAY 31 2002 | 8:10P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| CHARLOTTE HALL VETERANS HOME | CHARLOTTE HALL | ST. MARY'S |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-14-5196 | XX 1 M 2 F | 82 Yrs. | | | DEC. 29, 1919 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | ST. MARY'S | CHARLOTTE HALL | 1 ☐ Yes 2 XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 29449 CHARLOTTE HALL ROAD | 20622 | U. S. A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| XX 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: W.W. II | 1 ☐ Yes 2 ☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | CARPENTER | CARPENTRY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JAMES W. PURDUM | ELSIE JEAN WALTERS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| TARLTON E. WILLETT / NEPHEW | 24888 THREE NOTCH RD HOLLYWOOD, MD 20636 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | BRINSFIELD-ECHOLS CR. | JUNE 1, 2002 | CHARLOTTE HALL, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Joyce Barton Selby | BRINSFIELD-ECHOLS FUNL. HME., P.A. 30195 THREE NOTCH RD CHARLOTTE HALL, MD 20622 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Dysphagia | weeks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): hypernatremia | weeks |
| | c. Due to (or as a consequence of): Severe advanced dementia | years |
| | d. Due to (or as a consequence of): Chronic Renal insufficiency | years |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary disease
Sick Sinus Syndrome
Dehydration

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Daniel Glaun | D45092 | 5/31/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
110 Hospital Rd. Suite 303, Prince Fredrick, MD 20678

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 03 2002 | G. Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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State of Maryland / Department of Health and Mental Hygiene

**1-** For State Registrar

# Certificate of Death

Reg. No. 2002 18809

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Nam I. Park
2. Date of Death: Month May Day 25, Year 2002
3. Time of Death: 2123 M

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: N/A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 3, 1923
9. Birthplace (State or Foreign Country): Korea

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1825 Briggs Rd.
10f. Zip Code: 20906
10g. Citizen of What Country?: Korea

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 0
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Tae Hwa Park
18. Mother's Name (First, Middle, Maiden Surname): Nam Won

19a. Informant's Name/Relationship (Type, Print): Mr. Sung Shin- Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1825 Briggs Rd. Silver Spring, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Norbeck Mem. Park
Date: 05/29/2002
20c. Location - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee: K. E. Wi
22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): Hepatic Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of): End-Stage liver disease
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Steven Gruffermen MD
29c. License number: D 29348
29d. Date signed (Month, Day, Year): 5/25/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Gruffermen MD 1500 Forest Glen Rd. Silver Spring, MD 20910

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: G. Sparks

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ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18810

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Harvey V. Pearce
2. Date of Death Month Day Year: May 29, 2002
3. Time of Death: 7:30 PM
4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 562-28-1056
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 11, 1911
9. Birthplace *(State or Foreign Country)*: Oklahoma

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 503 Twinbrook Parkway
10f. Zip Code: 20851
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1944
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chief of Personnel/ Bureau of Mines
16b. Kind of Business/Industry: Department of the Interior

17. Father's Name *(First, Middle, Last)*: Alfred Dixon Pearce
18. Mother's Name *(First, Middle, Maiden Surname)*: Julia McNealy

19a. Informant's Name/Relationship *(Type, Print)*: Sadie N. Pearce / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 503 Twinbrook Parkway, Rockville, MD 20851

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park
Date: June 1, 2002
20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: Anne Marie Parker
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Non Hodgkins Lymphoma — 6 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D 35635
29d. Date signed *(Month, Day, Year)*: May 30, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Kaplan 18111 Prince Philip Drive , Olney, MD 20832

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 31 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND #8,6/4/2002,BMW,MoCo

# Certificate of Death

Reg. No. 2002 18811

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Euphemia Bryan Platte

2. Date of Death Month Day Year: May 28, 2002

3. Time of Death: 10:30am

4a Facility Name (If not institution, give street and number): Wilson Health Care Center

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

5. Social Security Number: 185-36-9223

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar ~~14~~ 4, 1913

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 301 Russell Avenue

10f. Zip Code: 20877

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Daniel Bunyan Bryan

18. Mother's Name (First, Middle, Maiden Surname): Affie Griffin

19a. Informant's Name/Relationship (Type, Print): Edward H. Platte (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4620 Reservoir Road, N.W., Washington, DC 20007

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 5/29/02

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Robert L. DeVol

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

**To Be Completed by Funeral Director**

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** Tha law raquires thet the death certificate ba executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. dementia — Approximate Interval: years

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other aignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☑ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Steven Dolinsky

29c. License number: D-20148

29d. Date signed (Month, Day, Year): May 28, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Dolinsky MD 911 Russell Ave, Gaithersburg Md

State Registrar

31. Date filed (Month, Day, Year): MAY 31 2002

32. Registrar's Signature: Geneva G. Sanders

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND #15,5/31/02,EMW,MoCo

# Certificate of Death

Reg. No. 2002 18812

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Donald Franklin Poole | May 27, 2002 | 8:35pm M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Casey House | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 171-32-6071 | 1☒ M 2☐ F | 61 Yrs. | | | Jan. 17, 1941 | Pennsylvania |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Rockville | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2 Maxim Lane | 20852 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| ~~2~~ | 2 | Cartographer | National Imagery & Mapping Agency |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Albert Franklin Poole | Almeda Helsel |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| M. Stella Poole (Wife) | 2 Maxim Lane, Rockville, MD 20852 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Metropolitan Crematory | 5/28/02 | Alexandria, Virginia |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Robert M. DeVol | DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** GF

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Lung Cancer | 1 Year |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown | 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? 1☐ Yes 2☒ No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No |
|---|---|

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

| 25. Was case referred to medical examiner? 1☐ Yes 2☒ No | 26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D54378 | 5/28/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Cheryl Aylesworth, MD 6910 Rockledge Drive #305, Bethesda, MD 20817

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | Geneva B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18813

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Constance Davis Quick
2. Date of Death (Month, Day, Year): May 25, 2002
3. Time of Death: 4:54 pm
4a. Facility Name *(If not institution, give street end number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-44-6100
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 8, 1930
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 13 Briggs Court
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. African American *Specify:*

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Travel Agent
16b. Kind of Business/Industry: Travel

17. Father's Name *(First, Middle, Last)*: Paul Davis
18. Mother's Name *(First, Middle, Maiden Surname)*: Constance Laurie Dennis

19a. Informant's Name/Relationship *(Type, Print)*: R. Edward Quick Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13 Briggs Court, Silver Spring, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Shiloh Baptist Church Cemetery
Date: 6/4/02
20c. Location - City or Town, State: Woodville, VA

21. Signature of Funeral Service Licensee: Andrè Thompson
22. Name and Address of Facility: McGuire Funeral Service, 7400 Georgia Ave. N.W., Washington, D.C. 20012

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute pneumonia | 1 wk. |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic renal disease, hypertensive arteriosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Myron L. Lenkin M.D.
29c. License number: 006674
29d. Date signed *(Month, Day, Year)*: May 29, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Myron L. Lenkin, M.D. 2309 Shorefield Road, Wheaton, MD 20902

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 31 2002
32. Registrar's Signature: Jeanne G. Koontz

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
STEVEN DOUGLAS RILL
02-2697-013

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18814

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| STEVEN DOUGLAS RILL | MAY 24, 2002 | 1030 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 208½ PENNSYLVANIA AVENUE | WESTMINSTER | CARROLL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-68-9641 | 1☒M 2☐F | 46 Yrs. | | | 5/11/1956 | PENNSYLVANIA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | CARROLL | WESTMINSTER | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 208 ½ PENNSYLVANIA AVE. | 21157 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | CARPENTER | CONSTRUCTION |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| GEORGE CALVIN RILL, SR. | ETHEL ROMAINE KALTRIDER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| RANDY RILL - BROTHER | 3321 SUTTON CT., MANCHESTER, MD. 21102 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | ALL COUNTY CREMATION | 5/26/02 | SYKESVILLE, MD. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility FLETCHER FUNERAL HOME
254 E. MAIN ST., WESTMINSTER, MD. 21157

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Upper Gastrointestinal Hemorrhage

Due to (or as a consequence of):
b. Associated with Hepatic Cirrhosis

Due to (or as a consequence of):
c. Chronic Alcoholism

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ J Pestaner M.D. | OCME | MAY 25, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

WJL
1

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrer

# Certificate of Death

Reg. No. 2002 18815

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| FRANK | MCKILL | RAINE JR | MAY 23, 2002 | 9:45 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 5889 Charles Cannon Road | Marion Station | Somerset |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 152-16-2146 | 1☒M 2☐F | 75 Yrs. | | | April 7, 1927 | New Jersey |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Somerset | Marion Station | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5889 Charles Cannon Road | 21838 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: WW II | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | - | Brick Mason | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frank McKill Raine Sr. | Wilhelmina Levallen |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Helen W. Raine/Wife | 5889 Charles Cannon Rd., Marion Station, MD 21838 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Salisbury Crematory | 5/24/02 | Salisbury, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| David H. Thompson, CFSP | Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CONGESTIVE HEART FAILURE | 48 hrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D0052293 | 5/23/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BALAKRISHNAN BALAGURUMURTHY, 11 E MAIN STREET, CRISFIELD MD-21817

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 24 2002 | [signature] |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

2 mp
IVA

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18816

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): RUTH ELIZABETH REED
2. Date of Death: Month 5 Day 22 Year 02
3. Time of Death: 12:00 P.M.
4a. Facility Name (If not institution, give street and number): 11374 - GREENWOOD SCHOOL RD.
4b. City, Town, or Location of Death: PRINCESS ANNE
4c. County of Death: SOMERSET

**Funeral Director**

5. Social Security Number: 218-30-2140
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-4-35
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: SOMERSET
10c. City, Town or Location: PRINCESS ANNE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11374 GREENWOOD SCHOOL RD.
10f. Zip Code: 21853
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LINE WORKER
16b. Kind of Business/Industry: DULANY CO.

17. Father's Name (First, Middle, Last): OSCAR FRANK DESHIELDS
18. Mother's Name (First, Middle, Maiden Surname): BEULAH M. COLLINS DESHIELDS

19a. Informant's Name/Relationship (Type, Print): NELLIE M. BISHOP TATEM DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15397 METOMPKIN RD. BLOXOM, VA. 23308

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. JAMES CEMETARY
Date: 5/28/02
20c. Location - City or Town, State: WESTOVER, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: BENNIE SMITH F/H 917-W. ISABELLA ST. SALISBURY, MD. 21801

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D24871
29d. Date signed (Month, Day, Year): 5/28/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 305 TENTH STREET POCOMOKE MD 21851 MARY L FLAY

3 MP

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: [signature] B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or Items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18817

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| CLARENCE VAN BUREN RIDGLEY, SR. | JUNE 01 2002 | 5:50 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HARFORD MEMORIAL HOSPITAL | HAVRE DE GRACE | HARFORD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-22-2644 | [X] M 2 [ ] F | 72 Yrs. | | | May 5, 1930 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Havre de Grace | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 700 Lafayette Street | 21078 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: unknown | 1 [ ] Yes 2 [X] No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Department Public Works | Harford County Gov. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Edward Ridgley, Sr. | Cassie Ann Warfield |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Agnes Ridgley / wife | 700 Lafayette Street, Havre de Grace, MD 21078 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Union United Meth Cem. | 6/8/02 | Aberdeen, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Lisa Scott | Lisa Scott Funeral Home 552 Lewis Street, Havre de Grace, MD 21078 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Ischemic CARDIOMYOPATHY | UKS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMA OF COLON, METASTATIC

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 [X] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ R de los Santos MD PA | D14836 | June 2, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RENE P. de los SANTOS
2835 CHURCHVILLE Road, Churchville, MARYLAND

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 03 2002 | ▶ Jennifer G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ridgley, Clarence V
from 1750 6/1/02
10+1VA

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2002 18818

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: HARRY A. RUSSELL, SR.

2. Dete of Death — Month: May; Dey: 27; Year: 2002

3. Time of Death: 2:35 PM

4a Facility Name *(If not institution, give street and number)*: Genesis ElderCare - The Pines

4b. City, Town, or Locetion of Deeth: Easton

4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 221-07-5521

6. Sex: X 1 M 2 F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: MAY 9 1914

9. Birthplace *(State or Foreign Country)*: DE

Usuel Residence of Decedent

10a. Stete: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: X 1 Yes 2 No

10e. Street and Number: 610 DUTCHMAN'S LANE

10f. Zip Code: 21601

10g. Citizen of Whet Country?: USA

11. Mantel Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes X 2 No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Eduction *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ESTIMATING ENGINEER

16b. Kind of Business/Industry: CHEMICAL MANUFACTURER

17. Father's Neme *(First, Middle, Last)*: HARRY E. RUSSELL

18. Mother's Name *(First, Middle, Maiden Surname)*: SOPHIA E. POKOISKI

19a. Informant's Name/Relationship *(Type, Print)*: RANDALL W. RUSSELL/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 27965 GLEBE RD. EASTON, MD 21601

20a. Method of Disposition: X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GULF PINES MEMORIAL PARK

Date: 6-1-2002

20c. Location - City or Town, State: ENGLEWOOD, FLORIDA

21. Signature of Funeral Service Licensee: JOHN R. MERCER JR LFSP

22. Name and Address of Fecility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Dementia — years

Due to (or es e consequence of):

b. Atherosclerosis — years

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Alcohol abuse

Hypothyroidism

Depression with psychotic features

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown

24a. Wes an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 6 Other *(Specify)*

27. Menner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner es steted. 2 **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature end title of certifier

29c. License number: D25933

29d. Date signed *(Month, Day, Year)*: 5.28.02

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): MICHAEL CROWLEY MD 508 IDLEWILD AVENUE EASTON, MD 21601

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 28 2002

32. Registrer's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Harry Russell
**Baltimore, Maryland 21215-0020**

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours efter death.
**To the Funeral Director:** Aftar this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use es the burial-transit

SBB

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18819

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| GRACE | ROBERTS | MAY 20, 2002 | 5:27 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| WASHINGTON ADVENTIST HOSPITAL | TAKOMA PARK | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 202-98-8970 | 1☐M 2☒F | 40 Yrs. | | | MAY 14,1962 | NIGERIA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | MONTGOMERY | TAKOMA PARK | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6731 NEW HAMPSHIRE AVE. | 20912 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | NURSE | NURSING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| DEALING ROBERTS | TONIPRE NUAFA |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| HELLEN DEALING/SISTER | 5802 ANNAPOLIS RD. #707, BLADENSBURG, MD. 20710 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | MT. OLIVET CEMETERY | 6-1-02 | WASHINGTON, D.C. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ W. H. Chambers M00091 | 5801 CLEVELAND AVE., RIVERDALE, MD. CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 20737 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

c. ACQUIRED IMMUNODEFICIENCY SYNDROME

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D46529 | MAY 21 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VICTOR ONYEGIAKA 7325A HANOVER PARKWAY GREENBELT MARYLAND

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | G. Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

02-2681-031
mnmr
Lee A. Records

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar UNPENDED 061202:ITEMS#23a,27,28a-f per ME 6608 ss

2002 18820
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Lee Andrew Records | May 23, 2002 | 9:36 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 20174 Timber Oak Lane | Germantown | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-92-7763 | 1[X] M 2[ ] F | 37 Yrs. | | | Dec. 17,1964 | Washington D.C. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Montgomery | Gaithersburg | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 101 Odendhal Avenue, Apt 105 | 20877 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Contractor | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lee M. Records | Marguerite Curtin |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John Records/ Brother | 7109 Exeter Road, Bethesda, MD 20814 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[ ] Burial 2[X] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | Metropolitan Cremetory | May 26 2002 | Alexandria, Virginia |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Tracy L. Sims | DeVol Funeral Home, 10 east Deer Park Drive, Gaithersburg, MD 20877 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. OXYCODONE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1[ ] Yes 2[ ] No 9[ ] Unknown | 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?
1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1[X] Yes 2[ ] No | 1[X] Yes 2[ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1[X] Yes 2[ ] No | Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA | Other: 4[ ] Nursing Home 5[ ] Residence 6[X] Other (Specify) at scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[ ] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[X] Could not be determined | Found: 5-23-02 | Found at: 9:34a M | 1[ ] Yes 2[X] No | Unknown |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Found at residence | 20174 Timber Oak Lane, Germantown, Maryland |

29a. Certifier (Check only one)
1[ ] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[X] **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | O.C.M.E. | May 24, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary G. Riffle, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | Jenna G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## *Certificate of Death*

Reg. No. 2002 18821

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Dudley T. Saunders, Sr.

2. Date of Death Month: May Dey: 26 Yeer: 2002

3. Time of Death: 1740

4a. Facility Name *(If not institution, give street end number)*: Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

**Funeral Director**

5. Social Security Number: 221-05-8976

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: Sept. 26, 1908

9. Birthplace *(State or Foreign Country)*: Orange, VA

Usuel Residence of Decedent

10a. State: DE

10b. County: New Castle

10c. City, Town or Location: Newark

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 904 Coventry Lane

10f. Zip Code: 19713

10g. Citizen of What Country?: USA

11. Meritel Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specity:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: railroad conductor

16b. Kind of Business/Industry: Pennsylvania RR

17. Father's Neme *(First, Middle, Last)*: Elhanon Saunders

18. Mother's Name *(First, Middle, Maiden Surname)*: Irene Johnson

19a. Informant's Name/Relationship *(Type, Print)*: Jeanette A. Seichepine (daughter)

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 20 Stature Dr. Newark, DE 19713

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gracelawn Mem. Park

Date: May 30, 2002

20c. Location - City or Town, State: New Castle, DE

21. Signature of Funeral Service Licensee: Nicholas A. Barbella 1000788

22. Name and Address of Facility: McCrory Funeral Homes, Inc. 3924 Concord Pike Wilm., DE 19803

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Bilatural pneumonia — 1 day

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28e. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0056698

29d. Date signed *(Month, Day, Year)*: MAY 26, 2002

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): JACINTO P. CASIO MD 1100 LOVERING AVE. SUITE 10-C WILMINGTON, DE 19806

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAY 29 2002

32. Registrer's Signature: Sandra G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

12

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18822

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Elizabeth Roberta Stewart | June 1 2002 | 1625 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Laurelwood Care Center | Elkton | Cecil |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-20-4709 | 1☐ M 2☒ F | 86 Yrs. | | | Feb. 18, 1916 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Cecil | Port Deposit | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 21 Center Street | 21904 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| Eleven Years | | Cook | Winchester's Restaurant Port Deposit, Maryland |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lou Harris | Myrtle Lee Thomas |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Clarence J. Stewart | 21 Center St., P.O. Box 4, Port Deposit, MD 21904 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Mt. Zoar Cemetery | 06/08/02 | Conowingo, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Thomas M. Patterson, Sr. | Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Oropharyngeal Dysphagia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebrovascular Accident

Due to (or as a consequence of):

c. Arthritis and contractures

Due to (or as a consequence of):

d. Alzheimer's Dementia

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | 056820 | 06/02/2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSEPH NISNISAN MD 223 WEST MAIN ST. ELKTON, MD 21921

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 04 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18823

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret Mary Sousane
2. Date of Death (Month, Day, Year): May 29, 2002
3. Time of Death: 9:40 P M
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-18-9187
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 28, 1920
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10003 Quinby Street
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Credit Manager
16b. Kind of Business/Industry: Retail Department Store

17. Father's Name (First, Middle, Last): Joseph Lepore
18. Mother's Name (First, Middle, Maiden Surname): Mary Joseph Hutton

19a. Informant's Name/Relationship (Type, Print): John N. Sousane / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17521 Queen Elizabeth Drive, Olney, MD 20832

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: June 3, 2002
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: John E. Parker
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ischemic Colitis — 4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Septic Shock — 5 days
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Renal Failure

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Mark S Rosen MD
29c. License number: D 20400
29d. Date signed (Month, Day, Year): May 30, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark S. Rosen, MD 3941 Ferrara Drive, Wheaton, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18824

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Derrick Andre Summerour
2. Date of Death (Month, Day, Year): MAY 24, 2002
3. Time of Death: 1550 M

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 215-72-8227
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 44 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 4, 1957
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 907 N. Stonestreet Avenue
10f. Zip Code: 20850
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Roy D. Summerour
18. Mother's Name (First, Middle, Maiden Surname): Estelle Brown

19a. Informant's Name/Relationship (Type, Print): Estelle Summerour (Mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 907 N. Stonestreet Ave., Rockville, MD 20850

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Park Cem.
Date: 5/31/02
20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME 246 N. Wash. St., Rockville, MD 20850

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** 7/6/02

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — 7 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. ADULT RESPIRATORY DISTRESS SYNDROME
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HEPATORENAL SYNDROME.
ALCOHOL ABUSE
PANCREATITIS.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D54347
29d. Date signed (Month, Day, Year): MAY 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NEERAJ CHOPRA 121 CONGRESSIONAL LANE, ROCKVILLE, MARYLAND

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

SUMMEROUR, DERRICK

5

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

CPM
02-2629-031
RENAN SOLANO

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061202:ITEMS#23a,27 per ME G808 SS

# Certificate of Death

Reg. No. 2002 18825

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Renon Alexis Carabaca Solano | MAY 21, 2002 | 8:23 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2376 GLENMONT CIRCLE APARTMENT 107 | WHEATON | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| N/A | 1☒M 2☐F | 22 Yrs. | | | 4/23/80 | Honduras |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md | Montgomery | Silver Spring | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2376 Glenmount Circle #107 | 20902 | Honduras |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☒Yes 2☐No Specify: Honduras | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6yrs | | Labor | Private |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jorge Aguilino Carabaca | Gloria Marino Solano |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jose A. Solano Uncle | 2376 Glenmont Circle#107 Silver Spring,Md |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Padre Alejandro | 6/7/02 | Honduras C.A. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Snead Funerl Home & Cremation Service 5732 Georgia Ave.NW Washington,DC |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS DUE TO NECROTIZING ENTEROCOLITIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? 1☒Yes 2☐No | 24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No |
|---|---|

| 25. Was case referred to medical examiner? 1☒Yes 2☐No | 26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE |
|---|---|

| 27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | | | | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | O.C.M.E. | MAY 22, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ [signature] G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18826

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Hwa Bee Sohn
2. Date of Death (Month, Day, Year): May 22, 2002
3. Time of Death: 9:20 P M
4a. Facility Name (If not institution, give street and number): 9611 Singleton Dr.
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 213-76-8922
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 8, 1920
9. Birthplace (State or Foreign Country): Korea

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9611 Singleton Dr.
10f. Zip Code: 20817
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 0
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Unknown Kim
18. Mother's Name (First, Middle, Maiden Surname): Jin Sook Min

19a. Informant's Name/Relationship (Type, Print): Hyong Sohn-Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9611 Singleton Dr. Bethesda, MD 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Norbeck Mem. Park
Date: 05/25/2002
20c. Location - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11300 New Hampshire Ave. Silver Spring, MD 20904

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Heart Failure | 10 Mins. |
| Due to (or as a consequence of): b. | Carcinoma of the Lung | 1 Yr. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] M.D.
29c. License number: D-19250
29d. Date signed (Month, Day, Year): May 23, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jae S. Chung, M.D. 9470 Annapolis Rd. Suite 306 Lanham, MD 20706

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2002 18827

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Helen Counter Shull

2. Dete of Death: Month: May; Dey: 23; Year: 2002

3. Time of Death: 4 28 PM

4e Facility Neme *(If not institution, give street end number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 522-14-6211

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 80 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: June 22, 1921

9. Birthplace *(Stete or Foreign Country)*: Colorado

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Montgomery

10c. City, Town or Location: Chevy Chase

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 8100 Connecticut Ave., #1409

10f. Zip Code: 20815

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): ; College (1-4or 5+): 4

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: Benjamin T. Counter

18. Mother's Name *(First, Middle, Maiden Surname)*: Marguerite Frink

19a. Informant's Name/Relationship *(Type, Print)*: John Shull/ Son

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 6107 Union Camp Dr., Fairfax Station, VA 22039

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fairfax Crematory

Date: May 29, 2002

20c. Location - City or Town, State: Fairfax, VA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death)

a. Hypernatremia

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest

b. Clostridia Difficile Colitis

Due to (or es a consequence of):

c. Meningitis

Due to (or as e consequence of):

d. Pituitary Adenoma

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Pressure Sores

Subdural Hygromas

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner steted.

29b. Signature end title of certifier: [signature]

29c. License number: 023767

29d. Date signed *(Month, Day, Year)*: May 25 2002

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Debra Wertheimer MD 2434 W. Belvedere Ave, Balto. MD 21215

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificete be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Helen Shull

25

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAY 28 2002

32. Registrer's Signeture: [signature] B. Sparks

DHMH 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760,**

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18828

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Lest)*: CHARLES E. SHAWVER
2. Dete of Deeth — Month: MAY Dey: 24 Year: 2002
3. Time of Death: 1:15 AM
4e Fecility Neme *(If not institution, give street end number)*: WILSON HEALTH CARE CENTER
4b. City, Town, or Location of Deeth: GAITHERSBURG
4c. County of Deeth: MONTGOMERY

**Funeral Director**

5. Social Security Number: 218-24-3540
6. Sex: 1☒M 2☐F
7. Age *(In yrs. lest birthday)*: 88 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 12,1914
9. Birthplace *(State or Foreign Country)*: Virginia

Usuel Residence of Decedent

10a. State: Florida
10b. County: Hillsborough
10c. City, Town or Location: Tampa
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 18209 Wimbledon Green Place
10f. Zip Code: 33647
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Detes: WWII
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+): 0
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Guard
16b. Kind of Business/Industry: Defense Department

17. Fether's Neme *(First, Middle, Last)*: Charles S. Shawver
18. Mother's Name *(First, Middle, Maiden Surname)*: Vannie E. Leffel

19a. Informant's Name/Relationship *(Type, Print)*: Edgar D. Shawver / Son
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 18209 Wimbledon Green Place, Tampa, Florida 33647

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Monocacy Cemetery
Date: 5/29/02
20c. Location - City or Town, State: Beallsville, Md.

21. Signature of Funeral Service Licensee: Muriel H. Barber
22. Name and Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Md. 20882

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Pneumonia — 5 Days
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure secondary to diabetic nephrosclerosis
Coronary artery disease
Hypertensive arteriosclerotic cardiovascular disease
Anemia of renal failure, congestive heart failure

23b. **Did tobecco use contribute to the cause of death?** 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28e. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner es steted. 2☐**Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: H. Robert Birschbach M.D.
29c. License number: D-04115
29d. Date signed *(Month, Dey, Year)*: May 24, 2002
30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): H. Robert Birschbach, M.D. 201 Russell Ave., Gaithersburg, Md. 20877

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAY 28 2002
32. Registrer's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5+1

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18829

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Kitty Murray Shore | May 29, 2002 | 3:55 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3812 Williams Lane | Chevy Chase | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-18-5937 | 1☐ M 2☒ F | 78 Yrs. | | | Feb. 8, 1924 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Chevy Chase | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3812 Williams Lane | 20815 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Banks Allen Murray | Elnora Womack |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Anthony M. Shore/Son | 7415 Oak Lane, Chevy Chase, Maryland 20815 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Montgomery Crematorium | May 30, 2002 | Bethesda, Maryland |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| Ray Lee | M00198 | Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Lung Cancer | 3 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer

Chronic Pulmonary Fibrosis

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| George A. Sotos | D43083 | May 29, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George A. Sotos, M.D. 9707 Medical Center Drive, Rockville, Maryland 20850

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | Geneva B. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18830

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jefferson Seabrook, Jr.

2. Date of Death: Month May Day 15, Year 2002

3. Time of Death: 5:30 AM

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 247-26-8344

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 15, 1922

9. Birthplace (State or Foreign Country): Charlotte, NC

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 437 Oxford Drive

10f. Zip Code: 20746

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No

If Yes, Give Year or Dates: 1944 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Long Shoreman

16b. Kind of Business/Industry: Shipyards

17. Father's Name (First, Middle, Last): Jefferson Seabrook, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Maryann Drayton

19a. Informant's Name/Relationship (Type, Print): Tonise Rhodes - Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 191-08 113th Avenue St. Albans, NY 11412

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Cemetery

Date: 5-20-02

20c. Location - City or Town, State: Brooklyn, New York

21. Signature of Funeral Service Licensee: Allen Woodall

22. Name and Address of Facility: Metropolitan Funeral Service 5517 Vine St. Alexandria, VA

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL HEMORRHAGE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CEREBRAL EDEMA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

ETOH ABUSE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D0048158

29d. Date signed (Month, Day, Year): 05-15-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SISOM OSIA, M.D. 6192 OXON HILL RD #500 OXON HILL MD 20745

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5-15-01 @ 5:30 AM

Seabrook, Jefferson - signed

CPM
02-2636-013
JOHN TUTHEROW

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18831

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOHN CURTIS TUTHEROW
2. Date of Death (Month, Day, Year): MAY 21, 2002
3. Time of Death: 22:04 M
4a. Facility Name (If not institution, give street and number): 3960 LITTLESTOWN PIKE
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

**Funeral Director**

5. Social Security Number: 251-52-7465
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 29, 1938
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3960 LITTLESTOWN PIKE
10f. Zip Code: 21158
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CARPENTER
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): JOHN H. TUTHEROW
18. Mother's Name (First, Middle, Maiden Surname): THELMA BENTLEY

19a. Informant's Name/Relationship (Type, Print): BETTIE G. TUTHEROW -WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11878 LEWISBURG RD.,LEWISBURG, KY 42256

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ALL COUNTY CREMATION | Date: 5/26/02
20c. Location - City or Town, State: SYKESVILLE, MD.

21. Signature of Funeral Service Licensee: R Lamy Ayres
22. Name and Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Gunshot wound to the Head

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 5/21/02 (FOUND)
28b. Time of Injury: 9:00 P. M.
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: SUBJECT SHOT SELF
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3960 LITTLESTOWN PIKE, MD WESTMINSTER

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): MAY 22, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

WJL 8

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18832

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gladys Taylor

2. Date of Death — Month: May Day: 23 Year: 2002

3. Time of Death: 6:45 pm

4a. Facility Name (If not institution, give street and number): St. Agnes Nursing & Rehabilitation Center

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 234-56-6128

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 23, 1917

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 950 River Road

10f. Zip Code: 21784

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 10 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): (Unknown) Keene

18. Mother's Name (First, Middle, Maiden Surname): Louisa Lester

19a. Informant's Name/Relationship (Type, Print): Mrs. Myrtle L. Fugate (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 950 River Road Sykesville, MD 21784

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Morningside Cemetery — Date: 5/29/02

20c. Location - City or Town, State: Renick, WV

21. Signature of Funeral Service Licensee: Brian K. Haight

22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Probable Carcinoma of Lung — 2 months

Due to (or as a consequence of):
b. Chronic Anemia

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
c. Senile Dementia

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: S Ramesh

29c. License number: D30641

29d. Date signed (Month, Day, Year): May 24 2002

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Ramesh Sabapathi 201-109 Back River Neck Road Baltimore MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrer's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

WJ 2

Steven Toop
CJ
02-2744-510

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18833

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Stephen Edward Toop | May | 26 | 2002 | 10:26 P.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Shock Trauma | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-84-9291 | 1☒M 2☐F | 40 Yrs. | | | Jan 23 1962 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Carroll | New Windsor | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2600 Old New Windsor Pike | 21776 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Truck Driver | Hahn Transportation Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Edward Toop | Elizabeth Ann Jones |

| 19a. Informant's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Andrea Toop/wife | 2600 Old New Windsor Pike New Windsor, MD 21776 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Westminster Cemetery | 5/31/2002 | Westminster, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| R. Lee Pritts Jr. | Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD 21157 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. MULTIPLE INJURIES | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a consequence of): | |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 5/26/02 | 16:54 P.M | 1☐Yes 2☒No | Driver of motor cycle that collided with truck |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Street | 407 Marston Road New Windsor, Maryland |

29a. Certifier (Check only one)
1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | O.C.M.E. | May 29, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ana Rubio, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | ▶ Geneva G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WSL 10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18834

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Frederick W. Thomas JR | May 22, 2002 | 1044 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 208-12-0206 | 1☒M 2☐F | 77 Yrs. | | | 2-28-25 | DE |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | WICOMICO | EDEN | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 734-CAMDEN AVE EXT. | 21822 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: NAVY "43-46" | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | CUSTODIAN | BOARD OF EDUCATION |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| FREDERICK W THOMAS SR | UNKNOWN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| LAVERNE DENNIS CROPPER - NEICE | 6943-SCOTLAND RD. SNOW HILL, MD. 21863 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | MT. WESLEY CEM. II | 5/28/02 | SNOW HILL, MD. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility BENNIE SMITH F/H
917-W. ISABELLA ST. SALISBURY, MD. 21801

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Cardiogenic shock | days |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | Coronary artery Disease | years |
| Due to (or as a consequence of): | | |
| c. | Heart failure | years |
| Due to (or as a consequence of): | | |
| d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D29749 | 5/23/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WILLIAM ROBINS, MD 1104 HEACHWAY DR. SALISBURY, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 24 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

208-12-0206

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Frederick Thomas

4 pp

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND #29d, 5/31/02, Per MD, McCo

# Certificate of Death

Reg. No. 2002 18835

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|
| Irving | Teitelbaum | May | 22 | 2002 | 11:45PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Casey House | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578-38-2464 | 1☒M 2☐F | 80 Yrs. | | | Sept. 1, 1921 | New York |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Bethesda | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5440 Marinelli Road #419 | 20852 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: WWII | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Manger | Paint & Hardware Store |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Josephe Teitelbaum | Pauline Tucker Teitelbaum |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lenita Teitelbaum (Wife) | 5440 Marinelli Road #419 Bethesda, MD 20852 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | 5-26-02 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Francine Bryant | Rapp Funeral And Cremation Service 933 Gist Avenue Silver Spring, MD 20910 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cancer Uknown Primary — Month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| | D35635 | May 22, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Kaplan 18111 Prince Phillip Drive #327 Olney, MD 20832

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | Geneva B. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Exar iner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physicien:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

# Certificate of Death

Reg. No. 2002 18836

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Gwin Franklin Tackett, Sr. | May 22, 2002 | 12:33 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Shady Grove Adventist Hospital | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 427-78-9202 | 1 [X] M 2 [ ] F | 61 Yrs. | | | Dec 31, 1940 | Mississippi |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Gaithersburg | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 407 Amberfield Lane | 20878 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1960-1993 | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Lieutenant Colonel | U.S. Army |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Pon A. Tackett, Sr. | Mary Ann Braswell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Judith M. Tackett, Wife | 407 Amberfield Lane, Gaithersburg, MD 20878 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Arlington Nat'l Cemetery | 6/25/02 | Arlington, Virginia |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | Minutes |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Coronary Artery Disease | Years |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No | 24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No |
|---|---|

| 25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No | 26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 [X] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ William Dooley M.D. | 033761 | May 22, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Dooley, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | ▶ Barbara B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18837

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Helen D. Thompson
2. Date of Death (Month, Day, Year): May 25, 2002
3. Time of Death: 10:20 AM
4a. Facility Name (If not institution, give street and number): 4866 Chevy Chase Blvd.
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-01-5235
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 30, 1904
9. Birthplace (State or Foreign Country): Massachusetts

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4866 Chevy Chase Blvd.
10f. Zip Code: 20815
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George F. Donovan
18. Mother's Name (First, Middle, Maiden Surname): Nellie Owens

19a. Informant's Name/Relationship (Type, Print): Charles W. Foster / Attorney
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 419 Seagull Drive, Lewes, DE 19958

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maple Street Cemetery
Date: June 1, 2002
20c. Location - City or Town, State: Adams, MA

21. Signature of Funeral Service Licensee: Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Breast Cancer | 6 months |
| Due to (or as a consequence of): b. | Pneumonia | 2weeks |
| Due to (or as a consequence of): c. | Dehydration | 2 weeks |
| Due to (or as a consequence of): d. | Anemia | 2 weeks |

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter G. Hamm MD
29c. License number: D 32033
29d. Date signed (Month, Day, Year): May 29, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter G. Hamm, MD 5530 Wisconsin Avenue, Chevy Chase, MD 20815

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: Jeanne B. Spader

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18838

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JAMES WILLIAM THOMAS JR | MAY 26, 2002 | 5:45 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| MONTGOMERY GENERAL HOSPITAL | OLNEY | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Dey, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-24-2414 | 1☒M 2☐F | 72 Yrs. | | | NOV 5, 1929 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 13308 TAMWORTH LANE | 20904 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1953 TO 1956 | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | ELECTRICAL ENGINEER | GOVERNMENT CONTRACT |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| JAMES WILLIAM THOMAS SR | HELEN CASTEEL |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MARY P THOMAS -SPOUSE | 13308 TAMWORTH LANE, SILVER SPRING MD 20904 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | LOUDON PARK CREMATORY | MAY 29 2002 | BALTIMORE, MARYLAND |

21. Signature of Funeral Service Licensee: Rosa Batrez

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME INC 11800 NEW HAMPSHIRE AVE, SILVER SPRING MD 20904

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ESOPHAGEAL CANCER | 6 WEEKS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a consequence of): | |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| | D 35635 | MAY 28, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH KAPLAN M.D. 18111 PRINCE PHILIP DRIVE, OLNEY MARYLAND 20832

**State Registrar**

| 31. Date filed (Month, Day, Yeer) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | Geneva B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 | 8839

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Alvin Maurice Thomas
2. Date of Death: Month May Day 27 Year 2002
3. Time of Death: 1825 PM
4a. Facility Name (If not institution, give street and number): Dorchester General Hospital
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

**Funeral Director**

5. Social Security Number: 215-38-0223
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 15, 1939
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Talbot
10c. City, Town or Location: Bellevue
10d. Inside City Limits: 1 ☐ Yes 2 ☑ No
10e. Street and Number: 5690 Gate Street
10f. Zip Code: 21662
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dishwasher
16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Charles Roger Thomas
18. Mother's Name (First, Middle, Maiden Surname): Thelma Holland

19a. Informant's Name/Relationship (Type/Print): Terence Henry, SR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5636-Church Hall Road-Royal Oak Maryland 21662

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Richard's Mem. Park
Date: 6/04/2002
20c. Location - City or Town, State: Easton, Maryland 21601

21. Signature of Funeral Service Licensee: Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St, Cambridge, Maryland 21613

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Metastatic colon Cancer — Approximate Interval Between Onset and Death: 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Type 2 DM

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jay D. Kerr, MD
29c. License number: D54840
29d. Date signed (Month, Day, Year): 5/30/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jay D. Kerr, MD 503A Muir St, Cambridge, MD

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18840

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Virginia A. Vogel

2. Date of Death (Month, Day, Year): May 26, 2002

3. Time of Death: 2:55 PM

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 579-10-4786

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 17, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15107 Interlachen Drive, #315

10f. Zip Code: 20906

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): -

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Robert James Archibald

18. Mother's Name (First, Middle, Maiden Surname): Lila May Charsha

19a. Informant's Name/Relationship (Type, Print): Karen A. Vogel/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1715 Westminster Way, Annapolis, Maryland 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: May 28, 2002

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: IMMEDIATE

Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY HEART DISEASE — UNKNOWN

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D24543

29d. Date signed (Month, Day, Year): MAY 27, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES A. ROSS, 3305 N. LEISURE WORLD BLVD, SILVER SPRING MD 20906

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

40

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18841

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Jeannette | VALE | May 28, 2002 | 7:35 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Manor Care -- Bethesda | Chevy Chase | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 551-22-4231 | 1☐M 2☒F | 90 Yrs. | | | June 2, 1911 | Texas |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Chevy Chase | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8700 Jones Mill Road | 20815 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Izzy Ornish | Lena Ornish |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Michelle Sender, Daughter | 2801 - 29th Place, NW, Washington, DC 20008 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mt. Lebanon Cemetery | 05/30/02 | Adelphi, MD |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Torchinsky Hebrew Funeral Home, Inc. 254 Carrell St., NW, Washington, DC 20012

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarct | 12 Hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Coronary Artery Disease | Indefinite |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] James J. Foster M.D. | D 04179 | May 30, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James J. Foster, M.D. 5530 Wisconsin Ave., Chevy Chase, MD 20895

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 31 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amend Item 19a per F.D. 05/29/2002 Carroll County, wjl

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18842

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LARAINE WIDERMAN

2. Date of Death Month: MAY Day: 26TH Year: 2002

3. Time of Death: 6:30 PM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 219-76-6324

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7/20/1942

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: BALTIMORE

10c. City, Town or Location: OWINGS MILLS

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 200 ROSEWOOD LANE

10f. Zip Code: 21117

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 0

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): BERNARD OLIVER WIDERMAN

18. Mother's Name (First, Middle, Maiden Surname): MILDRED PAULINE HOUSER

~~BERNARD O. WIDERMAN~~ BERNARD O. WILDERMAN (Informant's Name/Relationship, Print): FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 133 MARYDELL DR.,WESTMINSTER, MD. 21157

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ALL COUNTY CREMATION

Date: 5/28/02

20c. Location - City or Town, State: SYKESVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST.,WESTMINSTER, MD. 21157

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ASTHMA.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: PHYSICIAN

29c. License number: D42723

29d. Date signed (Month, Dey, Year): MAY 26 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AVVERAHALLI M HARISH NORTHWEST HOSPITAL CENTER 5401 OLD COURT RD MD 21133

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**To the Hospitel or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural', or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

LARAINE WIDERMAN

WJL 2

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18843

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Olga R. Wells

2. Date of Death: Month May, Day 25, Year 2002

3. Time of Death: 9:00 PM

4a. Facility Name (If not institution, give street and number): 1855 Deer Park Road

4b. City, Town, or Location of Death: Finksburg

4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 218-05-3607

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 03 1921

9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Finksburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1855 Deer Park Road

10f. Zip Code: 21048

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Trust Department

16b. Kind of Business/Industry: MD National Bank

17. Father's Name (First, Middle, Last): Leonard Sigfred Olsen

18. Mother's Name (First, Middle, Maiden Surname): Ruth Johnson

19a. Informant's Name/Relationship (Type, Print): L. Linwood Wells/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1855 Deer Park Road Finksburg, MD 21048

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fallston UMC Cemetery Date: 5/29/2002

20c. Location - City or Town, State: Fallston, MD

21. Signature of Funeral Service Licensee: R. Scott Pritts Jr

22. Name and Address of Facility: Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD 21157

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. metastatic rectal cancer — 1 yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John A Steers MD

29c. License number: MD D44614

29d. Date signed (Month, Day, Year): 5-28-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN A STEERS, MD 295 STONER AVE. SUITE 102 WESTMINSTER MD 21157

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 10

DHMH 17 Rev 1/2001

ORIGINAL

02-2728-015
mnmr
Oakley Washburn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 070902:ITEMS#23a,27,28a-f per ME 6809 ss

# Certificate of Death

Reg. No. 2002 18844

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Oakley Chaffin Washburn III
2. Date of Death: Month May, Day 26, Year 2002
3. Time of Death: 12:35 PM
4a. Facility Name (If not institution, give street and number): 1413 Conowingo Road
4b. City, Town, or Location of Death: Rising Sun
4c. County of Death: Cecil

**Funeral Director**

5. Social Security Number: 213-13-0533
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 16 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): April 23, 1986
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Rising Sun
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 202 Mount Street, Apt. 3-C
10f. Zip Code: 21911
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Native American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Home School

17. Father's Name (First, Middle, Last): SilverCloud Oakley Chaffin Washburn, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Diana LittleFlower Halsey

19a. Informant's Name/Relationship (Type, Print): Diana Washburn/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 202 Mount St., Apt. 3-C, Rising Sun, MD 21911

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Conowingo Baptist Cem. Date: 6-1-2002
20c. Location - City or Town, State: Conowingo, Maryland

21. Signature of Funeral Service Licensee: Richard L. Goodie
22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METHADONE INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

**Medical Certification; To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined
28a. Date of Injury (Month, Day Year) Found: 5-26-02
28b. Time of Injury Found at: 12:25 PM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found in dwelling
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1413 Conowingo Rd., Rising Sun, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Marjorie Bellville M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): May 27, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANNE P. KOREN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: Penny G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18845

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Patricia Rose Willis | May 28, 2002 | 1008 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Kent & Queen Anne's Hospital, Inc. | Chestertown | Kent |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-28-7849 | 1☐M 2☒F | 69 Yrs. | | | June 20 1932 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Kent | Galena | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 214 Phelps Ave. | 21635 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Assembly Line Worker | Electronic Manufacturer |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Karl Scandora | Rose Esler |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Robin McWhirt (daughter) | 9561 Hagel Circle Lorton, VA. 22079 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chester Cemetery | 6/1/02 | Chestertown, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ M00510 | Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — Approximate Interval: 24 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers Disease / HTN / DM Type II / ↑Chol / COPD / Emphysema

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☒Yes 2☐No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D 50996 | 5/29/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 Brown St. Chestertown, MD 21620

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18846

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Beatrice N. White
2. Date of Death: Month June Day 3 Year 2002
3. Time of Death: 11:00 AM
4a. Facility Name (If not institution, give street and number): 107 Wallace Avenue
4b. City, Town, or Location of Death: North East
4c. County of Death: Cecil

**Funeral Director**

5. Social Security Number: 212-01-7505
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): August 23, 1913
9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: North East
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 107 Wallace Avenue
10f. Zip Code: 21901
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): George W. Scarborough
18. Mother's Name (First, Middle, Maiden Surname): Ella Unknown

19a. Informant's Name/Relationship (Type, Print): Gary White/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 Wallace Avenue, North East, Maryland 21901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): North East Methodist Cemetery
Date: June 5, 2002
20c. Location - City or Town, State: North East, Maryland

21. Signature of Funeral Service Licensee: Robert E. Crouch
22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Dementia of Alzheimers Type — Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sachdev MD
29c. License number: D0023322
29d. Date signed (Month, Day, Year): 6/4/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S.S. Sachdev MD, 118 North 87 Suite 3B, Elkton MD 21921

**State Registrar**

31. Date filed (Month, Day, Year): JUN 04 2002
32. Registrar's Signature: P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18847

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROBERT WRIGHT

2. Date of Death (Month, Day, Year): May 30, 2002

3. Time of Death: 9:30 A M

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 225-10-1624

6. Sex: 1 X M 2 F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 12, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Indian Head

10d. Inside City Limits: 1 X Yes 2 No

10e. Street and Number: 88 Mattingly Avenue

10f. Zip Code: 20640

10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Planner Estimator

16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): Reginald Wright

18. Mother's Name (First, Middle, Maiden Surname): Blannie Welch

19a. Informant's Name/Relationship (Type, Print): Jeanette E. White-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8340 Venture Drive, Waldorf, MD 20603

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity Memorial Gdns

Date: 6-3-02

20c. Location - City or Town, State: Waldorf, MD

21. Signature of Funeral Service Licensee: Mark G. Brohawn M00053

22. Name and Address of Facility: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): ACUTE CEREBROVASCULAR ACCIDENT (STROKE) 2 DAYS

Due to (or as a consequence of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CANCER OF THE COLON WITH METASTICES

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D-18545

29d. Date signed (Month, Day, Year): MAY 30, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. WISOTSKY MD 12070 OLD LINE CENTER WALDORF, MD. 20602

**State Registrar**

31. Date filed (Month, Day, Year): JUN 06 2002

32. Registrar's Signature: G. Spencer

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18848

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Donald M. Wynne | May 21, 2002 | 1:05 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Montgomery Hospice Casey House | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 353-18-0659 | 1☒M 2☐F | 77 Yrs. | | | August 26, 1924 | Illinois |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Potomac | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8607 Postoak Road | 20854 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1942-1958 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use (retired)) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Electrical Engineer System Analyst | Government Contracts |
| | 5+ | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Donald Francis Wynne | Alice Whiting |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Helen H. Wynne/Wife | 8607 Postoak Road, Potomac, Maryland 20854 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Montgomery Crematorium, Inc | May 25, 2002 | Bethesda, Maryland |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| ▶ Angeletta Barnett | M01305 | Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Stroke | Days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Chitra Rajagopal | D42452 | May 22, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Chitra Rajagopal, M.D. 18111 Prince Phillip Drive, #327, Olney, Maryland 20832

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ Geneva G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

**Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1041

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18849

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: BETTS WOLK

2. Date of Death — Month: MAY Day: 24 Year: 2002

3. Time of Death: 10:15 AM

4a. Facility Name *(If not institution, give street and number)*: HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 046-32-6054

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 99 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11/03/1902

9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1801 EAST JEFFERSON STREET

10f. Zip Code: 20852

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER/ARTIST

16b. Kind of Business/Industry: OWN HOME/PAINTING COLLAGE

17. Father's Name *(First, Middle, Last)*: ISRAEL PRESSNER

18. Mother's Name *(First, Middle, Maiden Surname)*: ANNA STERNBERG

19a. Informant's Name/Relationship *(Type, Print)*: COLEMAN P. WOLK/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5273 HEATHER CIRCLE, EAST LANSING, MI 48823

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: NATIONAL CREMATORIUM

Date: MAY 29, 2002

20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. STROKE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☑ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gregory A Compton MD

29c. License number: D24942

29d. Date signed *(Month, Day, Yeer)*: MAY 24 2002

30. Name and address of person who completed cause of death *(Item 23e)* (Type, Print): GREGORY A. COMPTON, MD 6121 Montrose Rd Rockville MD

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 28 2002

32. Registrer's Signature: Geneva B. Sparks

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** 5

**To be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 8

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18850

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Mitchell Wilson | | May 23, 2002 | 4:15 A. M |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | |
| Montgomery General Hospital | Olney | Montgomery | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 237-76-0786 | 1 [X] M 2 [ ] F | 55 Yrs. | | | Dec 9, 1946 | North Carolina |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Gaithersburg | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 14644 Quince Orchard Road | 20878 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: American Indian |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Self Employed | Auto Repair |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Marshall Wilson | Gladys Richardson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia E. Wilson, Wife | 14644 Quince Orchard Road, Gaithersburg, MD 20878 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Parklawn Memorial Park | 5/31/2002 | Rockville, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ADENOCARCINOMA LUNG | 5 MONTHS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown | 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| [signature] | D35635 | May 23, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Kaplan, M.D., 18111 Prince Philip Drive, Olney, Maryland 20832

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18851

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Florence Evelyn Wiley

2. Date of Death: Month May, Day 24, Year 2002

3. Time of Death: 12:05 A.M

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 300-07-0812

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): July 31, 1913

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 415 Russell Avenue, # 308

10f. Zip Code: 20877

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Carl Whitmer

18. Mother's Name (First, Middle, Maiden Surname): Sara Jane Robertson

19a. Informant's Name/Relationship (Type, Print): Turner N. Wiley/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 415 Russell Ave,#308, Gaithersburg, MD. 20877

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 5/24/2002

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Michael J. Sheehan

22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Rectal Carcinoma — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____ Due to (or as a consequence of):

c. ____ Due to (or as a consequence of):

d. ____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) ____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and titte of certifier: Chitra Rajagopal

29c. License number: D 42452

29d. Date signed (Month, Day, Year): May 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chitra Rajagopal, M.D., 18111 Prince Philip Drive, Olney, Maryland 20832

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: Donna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18852

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Willie F. Wharton

2. Date of Death: Month May Day 20, Year 2002

3. Time of Death: 10:30 AM

4a. Facility Name *(If not institution, give street and number)*: 13919 Blair Stone Ln.

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 579-48-6124

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 2, 1910

9. Birthplace *(State or Foreign Country)*: Virginia

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13919 Blair Stone Ln.

10f. Zip Code: 20906

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Jacob A. Funkhouser

18. Mother's Name *(First, Middle, Maiden Surname)*: Hattie M. Webb

19a. Informant's Name/Relationship *(Type, Print)*: Faye E. Wharton / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13919 Blair Stone Ln. Silver Spring, MD. 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Norbeck Memorial Park

Date: 5/24/02

20c. Location - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee: Richard Turner

22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): Cardiopulmonary Arrest

Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of): Polymyalgia Rheumatica

b. Due to (or as a consequence of): Old Age

c. Due to (or as a consequence of): Hypertension

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kanwaljit Nagi M.D.

29c. License number: D0056063

29d. Date signed *(Month, Day, Year)*: 5/29/02.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kanwaljit Nagi, M.D. 10810 Connecticut Ave. Kensington, MD 20895

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 29 2002

32. Registrar's Signature: Jennie B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** CF

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No: 2002 18853

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Elizabeth T. Whalen

2. Date of Death Month Day Year: May 25, 2002

3. Time of Death: 5:00 AM

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Rehabilitation and Nursing Center

4b. City, Town, or Location of Death: Burtonsville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-03-6116

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 13, 1917

9. Birthplace *(State or Foreign Country)*: DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 224 Sophia Avenue

10f. Zip Code: 21157

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Clerical

17. Father's Neme *(First, Middle, Lest)*: Jessie Thomas

18. Mother's Name *(First, Middle, Maiden Surname)*: Esther Marden

19a. Informant's Name/Relationship *(Type, Print)*: Thomas A. Whalen / Son

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 224 Sophia Avenue, Westminster, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory, or other place)*: George Washington Cemetery

Date: 5/30 2002

20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: Andrew J. Cole

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Failure

Due to (or as a consequence of):

b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence of):

c. Febrile illness

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

STATUS Post (R) hip hemiarthroplasty

Coronary Artery Disease S/p STENT

H/o Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Gary E. Raffel DO FACP

29c. License number: H45839

29d. Date signed *(Month, Dey, Year)*: 5/25/02

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): GARY E. RAFFEL, DO, FACP; 5411 W. Cedar Lane #302A Bethesda, 20814

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAY 29 2002

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18854

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Donald C. Weaver
2. Date of Death (Month, Day, Year): May 24 2002
3. Time of Death: 7:45 PM
4a. Facility Name (If not institution, give street and number): Casey House
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 162-12-9036
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 1, 1920
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Monrovia
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 12401 Lee Hill Drive
10f. Zip Code: 21770
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No WWII If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive Officer
16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): George Ellery Weaver
18. Mother's Name (First, Middle, Maiden Surname): Laura Mae Culp

19a. Informant's Name/Relationship (Type, Print): Mildred E. Weaver/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12401 Lee Hill Drive, Monrovia, Maryland 21770

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium
Date: May 27,2002
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: John P. Cropley M00092
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Lung Cancer — Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chitra Rajagopal
29c. License number: D42452
29d. Date signed (Month, Day, Year): May 25, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chitra Rajagopal, M.D. 18111 Prince Phillip Drive, #327 Olney, Maryland 20832

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18855

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ethel Day Waring

2. Date of Death Month Day Year: May 24, 2002

3. Time of Death: 4:41 AM M

4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 187-09-7548

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 3, 1918

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 433 Christopher Avenue #13

10f. Zip Code: 20879

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeper

16b. Kind of Business/Industry: Bookkeeping

17. Father's Name *(First, Middle, Last)*: John Rowe

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Bechtel

19a. Informant's Name/Relationship *(Type, Print)*: Linda Waring-Wilson

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8509 West Virginia Avenue Lakewood, Colorado 80226

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium Inc.

Date: May 29, 2002

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M00335

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism — Due to (or as a consequence of): — hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Polycythemia vera — Due to (or as a consequence of): — 18 months

c. — Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Cheryl Winchell MD

29c. License number: D14555

29d. Date signed *(Month, Day, Year)*: May 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cheryl Winchell, 19241 Montgomery Village Ave, Mont. Village MD 20886

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 30 2002

32. Registrar's Signature: [signature] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Amended Item #10e, Per F.D., 05/28/2002, Carroll County,cew

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18856

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Catherine Frances Zuna-Smith

2. Date of Death (Month, Day, Year): May 24, 2002

3. Time of Death: 3:30 p M

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 219-10-1147

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 25, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Manchester

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4920 Crossroads Schoolhouse Rd. ~~4920 Croosroads Schoolhouse Rd~~

10f. Zip Code: 21102

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John A. Schultz

18. Mother's Name (First, Middle, Maiden Surname): Viola Kofskey

19a. Informant's Name/Relationship (Type, Print): John Zuna, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5211 Sidney Road, Mt. Airy, Md 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem

Date: 05/29/2002

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Steven W Elmer M00723

22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a CVA — 48 h

Due to (or as a consequence of): b. AML — 10mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery (Month, Day, Year)

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D25493

29d. Date signed (Month, Day, Year): 5/25/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. John Middleton, 688c Poole RD, Westminster, MD 21157

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature: Jeanne G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12 cew

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18857

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Eugene | A. | Avens Jr. | June 7 2002 | 3:30a. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3721 Sylvan Drive | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 246-70-1899 | 1 X M 2 ☐ F | 52 Yrs. | | | 01 21 50 | NC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3721 Sylvan Drive | 21207 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | 1 yr | Correctional Officer | State of Maryland |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Eugene Avens Sr. | Julia Ashe |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sandra E. Avens-Wife | 3721 Sylvan Drive, Baltimore Md 21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Woodlawn Cemetery | 6/12/02 | Baltimore Co, Md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Kale March | March F/H West 4300 Wabash Ave, Baltimore Md 21215 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myo Cardinal Infarction. | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Hypertension Due to (or as a consequence of): | |
| | c. Arteriosclerotic Cardio Vascular Disease Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Obesity

| 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown | |
|---|---|
| 24a. Was an autopsy performed? 1 ☐ Yes 2 X No | 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? 1 X Yes 2 ☐ No | 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) |
|---|---|

| 27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | | | | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Charles F. O'Donnell MD | D-09383 | June 8, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles F. O'Donnell MD 111 Hamlet Hill Rd Baltimore Md 21210

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 | 8858

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY E. ALLEN

2. Date of Death (Month, Day, Year): June 8, 2002

3. Time of Death: 2:35 A M

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-44-5014

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-20-1913

9. Birthplace (State or Foreign Country): NORTH CAROLINA

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2☐ No X

10e. Street and Number: 1731 W. NORTH AVE.

10f. Zip Code: 21217

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: XX

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): -12-

College (1-4or 5+): -0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BEAUTICIAN

16b. Kind of Business/Industry: COSMETOLOGY

17. Father's Name (First, Middle, Last): HENRY ALSTON

18. Mother's Name (First, Middle, Maiden Surname): MARINA ALSTON

19a. Informant's Name/Relationship (Type, Print): SHIRLEY W. RICHARD (NIECE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6210 PARK HEIGHTS AVE. APT 501 BALTIMORE, MARYLAND 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK

Date: 6-13-2002

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Tonatha O. Hebron

22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Encephalopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Renal Insufficiency

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chukwuma Ebo

29c. License number: 89455

29d. Date signed (Month, Day, Year): June 8, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chukwuma E. Ebo MD, C/o Maryland General Hospital

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002

32. Registrar's Signature: Barbara G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

MARY ALLEN

**Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18859

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Miracle Boyd
2. Date of Deeth: Month June; Dey 11; Year 2002
3. Time of Death: 1:08 AM
4e. Facility Neme *(If not institution, give street end number)*: 5000 Corley St., Apartment B5
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth: Baltimore

**Funeral Director**

5. Social Security Number: 212-51-3904
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. lest birthday)*: 4 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 8-29-1997
9. Birthplace *(State or Foreign Country)*: MD

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Baltimore
10c. City, Town or Location: Woodlawn
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 5000 Corley Road
10f. Zip Code: 21207
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☑ Never Merried 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☑ No If Yes, Give Year or Detes:
13. Was Decedenf of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Educetion *(Specify only highest grede completed)*: Elementery/Secondary (0-12): Pre-K; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: N/A
16b. Kind of Business/Industry: N/A

17. Father's Neme *(First, Middle, Last)*: Vahndel Pattillo
18. Mother's Name *(First, Middle, Maiden Surname)*: Rachel Boyd

19a. Informant's Name/Reletionship *(Type, Print)*: Rachel Boyd (Mother)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5000 Corley Rd. Woodlawn, MD 21207

20a. Methed of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: Woodlawn Cemetery
Date: 6/17/02
20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name and Address of Feciliby: Vaughn C Greene Funeral Svc. 5151 Balto. Nat'l Pike Balti. MD. 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): e. Anaplastic Astrocytoma — 1 ½ years

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lasf

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the causa of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: ▶ Jason Sager, MD
29c. License number: S-2022
29d. Date signed *(Month, Day, Year)*: June 11 2002

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Jason Sager, MD Johns Hopkins Hospital, 600 North Wolfe Street, CMSC 800 Baltimore MD 21287

**State Registrar**

31. Dete filed *(Month, Day, Year)*: JUN 12 2002
32. Registrer's Signature: Jeanne B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar: AMEND ITEM #30 PER DVR G808 6/12/02 JH

Reg. No: 2002 18860

## Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOSSIE BAILEY
2. Date of Death — Month: 06 Day: 09 Year: 02
3. Time of Death: 0424 AM M
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE MD
4c. County of Death: N/A

## Funeral Director

5. Social Security Number: 229 46 2283
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:
8. Date of Birth (Month, Day, Year): 06 13 29
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1208 N. Stricker St.
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Nursing Home

17. Father's Name (First, Middle, Last): Grant Bailey
18. Mother's Name (First, Middle, Maiden Surname): George Anna Brown
19a. Informant's Name/Relationship (Type, Print): (daughter) Deborah Ann Bailey
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1208 Stricker St. Balto. MD. 21217

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Park
Date: 6/14/02
20c. Location - City or Town, State: Randallstown, MD.

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name and Address of Facility: Vaughn C. Greene Funeral Svc. 5151 Balto. Nat'l Pike Balto. MD. 21229

## Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. CARDIOPULMONARY ARREST

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. SEPSIS
Due to (or as a consequence of):
c. END STAGE RENAL DISEASE
Due to (or as a consequence of):
d. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery — Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
DIABETES MELLITUS
OBESITY

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) — Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ F. A Hamilton MD MEDICAL STAFF
29c. License number: D08291
29d. Date signed (Month, Day, Year): JUNE 9, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANK A. HAMILTON BON SECOURS HOSPITAL BALTIMORE MD.

## State Registrar

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 | 8861

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Dete of Death Month / Dey / Yeer | 3. Time of Death |
|---|---|---|---|---|
| Lillian | Frances | Boston | June 11 2002 | 1:15am |

| 4e Fecility Neme (If not institution, give street end number) | 4b. City, Town, or Locetion of Deeth | 4c. County of Death |
|---|---|---|
| 3318 Egerton Road 2nd Floor | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. lest birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-28-4091 | 1☐ M 2☒ F | 72 Yrs. | | | 08 11 29 | MD |

Usuel Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street end Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 3318 Egerton Road 2nd Floor | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10th grade | na | Cafeteria Worker | Montgomery Wards |

| 17. Father's Neme (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Hill | Beatrice Foster |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Rosetta Jackson-Sister | 3318 Egerton Road 2nd Floor, Baltimore Md 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Arbutus Memorial Park | 6/17/02 | Arbutus, Md |

21. Signature of Funeral Service Licensee: Glynna B Keke

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximete Interval Between Onset end Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. Lung Carcinoma | months |
| | Due to (or as e consequence of): | |
| Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as e consequence of): | |
| | c. | |
| | Due to (or as e consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☒ **Unknown**

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Menner of Death | 28e. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner as steted.
2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| Jyotin Pasikhani | D32158 | 6/11/02 |

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)
Jyotin Pasikhani 821 N. Eutaw St, Suite 407, Baltimore, MD 21201

**State Registrar**

| 31. Dete tiled (Month, Day, Year) | 32. Registrer's Signature |
|---|---|
| JUN 12 2002 | Regina D Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2002 18862

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Charles Edward Boyd Jr.

2. Date of Death Month / Day / Year: June 6, 2002

3. Time of Death: 1700

4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 219-86-6985

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 28 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 16 1973

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3827 Crestlyn Road

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Artist

16b. Kind of Business/Industry: Self Employed

17. Father's Name *(First, Middle, Last)*: Charles Edward Boyd Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Freda Mitchell

19a. Informant's Name/Relationship *(Type, Print)*: Freda Reed/Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3827 Crestlyn Road Balto. MD 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Zion Cemetery

Date: June 15,2002

20c. Location - City or Town, State: Landsdowne

21. Signature of Funeral Service Licensee: Edward R Temple

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto.MD 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Exacerbation of Asthma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvester, DO

29c. License number: MD053727

29d. Date signed *(Month, Day, Year)*: June 7, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

**State Registrar**

31. Date filed *(Month, Day, Year)*: JUN 12 2002

32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18863

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): MARTIN BALLISTRERI
2. Date of Death: Month June Day 8 Year 2002
3. Time of Death: 11:50 PM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A
5. Social Security Number: 216-28-8613
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 24, 1932
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Berkshire
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 7604 Carson Avenue
10f. Zip Code: 21224
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1950-53
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 6 Years
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson
16b. Kind of Business/Industry: Sales

17. Father's Name (First, Middle, Last): Albert Ballistreri
18. Mother's Name (First, Middle, Maiden Surname): Harriett Lentz

19a. Informant's Name/Relationship (Type, Print): Wife Mrs. Hazel A. Ballistreri
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7604 Carson Avenue Baltimore, Maryland 21224

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery
Date: 6/13/2002
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Dan C. Carroll
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — Approximate Interval Between Onset and Death: 1 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Advanced Metastatic Liver Disease WITH ASCITES — due to (or as a consequence of): — 1 year
c. Colon CA — due to (or as a consequence of): — 4 years
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease, Diabetes

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Paul Guarino MD
29c. License number: 21006
29d. Date signed (Month, Day, Year): June 8, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL GUARINO, MD / Johns Hopkins Bayview Medical Center / 4940 Eastern Ave / Baltimore MD 21224

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

1271

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Brent E. Butler
02-2914-510
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061302:ITEMS#23a,27,28a-f per ME G808 ss

# Certificate of Death

Reg. No. 2002 18864

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BRENT E. BUTLER
2. Date of Death: Month June, Day 03, Year 2002
3. Time of Death: 5:12 A M
4a. Facility Name (If not institution, give street and number): 1936 Eager Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-88-0860
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 39 Yrs.
If Under 1 Year: Months; If Under 24 Hrs.: Days, Hours, Min.
8. Date of Birth (Month, Day, Year): April 25, 1963
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 1507 N. CHAPEL ST.
10f. Zip Code: 21213
10g. Citizen of What Country? USA

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRODUCE SALESMAN
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): LE ROY BUTLER
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): CATHERINE SUTLES/SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1637 NORMAL AVE BALTIMORE, MD 21213

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 6-11-2002
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: [signature] MD1015
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL HM. 4905 YORK RD. BALTIMORE, MD 21212

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined
28a. Date of Injury (Month, Day Year): Found: 6-3-02
28b. Time of Injury: Found: 5:05A M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found: private dwelling
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1936 Eager St., Baltimore, MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☐ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): June 03, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: [signature] B. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18865

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Virginia Lee Berlau

2. Date of Death (Month, Day, Year): June 11, 2002

3. Time of Death: 11:05 A M

4a. Facility Name (If not institution, give street and number): 2532 Londonderry Road

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-34-5998

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 15, 1937

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2532 Londonderry Road

10f. Zip Code: 21093

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Nursery School

17. Father's Name (First, Middle, Last): Sherman O. Canapp

18. Mother's Name (First, Middle, Maiden Surname): Isabelle S. Lavender

19a. Informant's Name/Relationship (Type, Print): Donald H. Berlau / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2532 Londonderry Road Timonium, Maryland 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Cem.

Date: 6/14/02

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service License: Earl L. Canapp, CFSP

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Towson, Md. 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GLIOBLASTOMA MULTIFORME — 1.5 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stuart Grossman M.D

29c. License number: D23683

29d. Date signed (Month, Day, Year): 6/11/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STUART GROSSMAN MD JOHNS HOPKINS ONCOLOGY CENTER BALT. MD

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002

32. Registrar's Signature: Barbara B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18866

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|---|
| HERBERT | BEARMAN | May 25, 2002 | 9:24 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-12-9509 | 1☒M 2☐F | 88 Yrs. | | | Aug. 23, 1913 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8911 Reisterstown Road | 21208 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | INVESTOR | INVESTMENT |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| SOL BEARMAN | ROSE HARTZ |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| DR. SHELDON BEARMAN/NEPHEW | 23 WALLY COURT, LUTHERVILLE, MD 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | BETH JACOB CONG. | 05/28/2002 | FINKSBURG, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Ari Oberstein per DVR | SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

b. Deep Venous Thrombosis

Due to (or as a consequence of):

c. Femoral Neck Fracture

Due to (or as a consequence of):

d. Chronic Obstructive Pulmonary Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death: Hours / Days / Weeks / Years

CERTIFICATION APPROVED BY MEDICAL EXAMINER

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☑No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☑Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☑DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☑Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | May 11, 2002 | Unknown M | 1☐Yes 2☑No | Fall From Standing |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Residence | Levindale Nursing Center |

29a. Certifier (Check only one)

1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D0053495 | May 31, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RYAN M KRAMER MD SINAI HOSPITAL OF BALTIMORE 2401 W BELVEDERE AVE BALTIMORE MD 21215

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18867

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ALTHESIA G. BROWNLEY
2. Dete of Deelh: Month JUNE, Dey 10, Year 2002
3. Time of Death: 1:15am
4e. Facility Name (If not institution, give street end number): 3112 PIEDMONT AVE.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Deeth: N/A

**Funeral Director**

5. Social Security Number: 220-14-2434
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dale of Birth (Month, Dey, Year): 6-2-1925
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usuel Residence of Decedent

10a. Stele: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3112 PIEDMONT AVE.
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12- ; College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: SOCIAL SERVICE

17. Father's Name (First, Middle, Last): JAMES GRAY
18. Mother's Name (First, Middle, Maiden Surname): JANIE GRAY

19a. Informant's Name/Relationship (Type, Print): THOMAS C. BROWNLEY (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3112 PIEDMONT AVE. BALTIMORE, MARYLAND 21216

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK
Date: 6-13-2002
20c. Locelion - Cily or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Jonatha D. Hubner
22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident

Due to (or es e consequence of):
b. Arteriosclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☑ No
26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Nelurel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: Stephen Siegel MD
29c. License number: D 28304
29d. Date signed (Month, Day, Yeer): 6/10/02

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Stephen Siegel MD 750 Main St. Reisterstown MD 21136

**State Registrar**

31. Dete filed (Month, Day, Year): JUN 12 2002
32. Regislrer's Signeture:

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18868

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Dorthea Collins | June 2 2002 | 11:50 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| North Arundel Hospital | Glen Burnie | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Dey, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 184-18-0230 | 1☐ M 2☒ F | 81 Yrs. | | | Feb. 25,1921 | West Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Glen Burnie | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 313 Hospital Drive | 21061 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Sales Representative | Retail |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Kirby Collins | Flora Morrison |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Freida Collins (Sister-in-law) | 1297 Ashburton Drive, Millersville, MD 21108 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Metro Crematory | 06/06/2002 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 |

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked othar than "natural', or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Hemorrhagic Stroke | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☑ No 9☐ Unknown | 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Madical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ [signature] MD | D 43977 | June 3 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Onyeka Onwuanyi. 301 Hospital Drive, Glen Burnie MD 21061

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law raquires that the death certificate be executed within 24 hours after death.
To tha Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by tha funeral director, page 2 should ba detached for use as tha burial-transit

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18869

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Wilkie M. Campbell
2. Date of Death Month Day Year: June 8 2002
3. Time of Death: 11:15A M
4a. Facility Name (If not institution, give street and number): Northwest Hospital
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 155-14-6034
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 83 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09 19 18
9. Birthplace (State or Foreign Country): AL

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: XXYes 2☐No
10e. Street and Number: 59 Mountain Green Cir
10f. Zip Code: 21244
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced X
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No X If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No X Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurses Aid
16b. Kind of Business/Industry: Medical Center

17. Father's Name (First, Middle, Last): Wilkie Moore
18. Mother's Name (First, Middle, Maiden Surname): Gertrude Baker

19a. Informant's Name/Relationship (Type, Print): Donna Green-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 59 Mountain Green Cir., Baltimore Md 21244

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) X
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park
Date: 6/12/02
20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Dale March
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. ACUTE ABDOMINAL ABSCESS.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PROGRESSIVE SUPRANUCLEAR PALSY
COAGULOPATHY

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Rangaraju MD
29c. License number: D54288
29d. Date signed (Month, Day, Year): June 8th 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMASWAMY I RANGARAJAN, NORTHWEST HOSPITAL CENTER.

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: Bonnie B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #23d @# PTII PER PHY G808 6/24/02 JH

# Certificate of Death

Reg. No. 2002 18870

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Randall Carter

2. Dete of Deeth: Month: May; Dey: 31; Year: 2002

3. Time of Death: 8:25 pm

4e Feciity Neme (If not institution, give street end number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

5. Social Security Number: 341-22-2974

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): Feb 14 1931

9. Birthplace (State or Foreign Country): Illinois

Usuef Residence of Decedent

10a. Stete: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street end Number: 4002 Wilsby Avenue

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 years

College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Balto City Dept. of Public Work Water Treatment

17. Father's Name (First, Middle, Last): Walter Carter

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Curry

19a. Informant's Name/Relationship (Type, Print): Mary L. Smith/ friend

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 4002 Wilsby Ave Balto., MD 21218

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Warren Cemetery

Date: June 6, 2002

20c. Location - City or Town, State: Gurnee, IL

21. Signature of Funeral Service Licensee: Herbert E. Nutter

22. Name and Address of Feciity: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto., MD 21216

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in deeth)

a. Systemic InFlammatory Response Syndrome — 10 days

Due to (or es a consequence of):

b. Liver Failure — 6 month

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Renal failure — 3-4 months

Due to (or es e consequence of):

d. SEPSIS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ETOH ABUSE, LIVER DISEASE

23b. Did tobecco use contribute to the cauee of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Phyeician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medicai Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lana Al-Samara

29c. License number: AT2438946

29d. Date signed (Month, Day, Year): May, 31, 2002

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Lana Al-Samara, Union Memorial Hospital, 201 East University Parkway Baltimore MD 21218

State Registrar

31. Date filed (Month, Day, Year): JUN 12 2002

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** Tha law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** Aftar this certificate has been signed by the attanding physician and completely filled in by the funaral director, paga 2 should be datached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**1- For State Registrar** — *Certificate of Death* — Reg. No. 2002 18871

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Norma | Collins | Chandler | June 10, 2002 | 12:30 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 6 Bailiffs Court # 201 | Timonium | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-32-1551 | 1 ☐ M 2 ☒ F | 69 Yrs. | | | 02/05/1933 | Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Timonium | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| #6 Bailiffs Court #201 | 21093 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Admin. Accountant | Medical Manufacturing |
| | 1 | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Burton Leon Collins | Ruth Emma Zinn |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Paul Chandler/son | 616 West 34th Street Baltimore, Maryland 21211 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Hilltop Service Corp | 06/14/2002 | Towson, Maryland |

21. Signature of Funeral Service Licensee: Myles D Collector M01122

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Hypertension | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Hypercholesterolemia | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

If FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Myles D Collector MD | D44271 | 6/11/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Daniel Collector, M.D.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | Barbara G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18872

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Michael B. Clinedinst
2. Date of Death (Month, Day, Year): JUNE 9, 2002
3. Time of Death: 8:10 PM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-58-7488
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 45 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 4 1956
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 858 Jeannette Ave.
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): +1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Burger King

17. Father's Name (First, Middle, Last): Allen B. Clinedinst
18. Mother's Name (First, Middle, Maiden Surname): Eleanor Krawczykowski

19a. Informant's Name/Relationship (Type, Print): Mr. Allen Clinedinst/ Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1912 Ridgewood Ct. Hampstead, Md. 21074

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cemetery
Date: 6-13-02
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc 1050 York Rd. Towson, Md. 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of): METASTATIC LUNG CANCER
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Joginder P Mehta M.D
29c. License number: D 0041110
29d. Date signed (Month, Day, Year): June 9th, 2002.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P. MEHTA, M.D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: [signature] Gordon G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Tamalyn Coxen
02-2878-510
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18873

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Tamalyn R. Coxen | May | 24 | 2002 | 10:43 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical Center | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | Days | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 201-44-3197 | 1☒M 2☐F | 46 Yrs. | | | | | August 9, 1955 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| NJ | Burlington | Willingboro | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 16 Henderson Lane | 08046 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | Entrepreneur | Refurbished Homes |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Unobtainable | Joan L. Coxen |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Orville Coxen / Uncle | 164 Henderson Lane Willingboro NJ 08046 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Bay View Crematory | June 3, 2002 | Baltimore Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Victor P. Doda, Jr. | Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Intracerebral hemorhage | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] MD | O.C.M.E. | June 01, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | [signature] |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Exer. mer must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18874

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dorothy Elliott
2. Date of Death: Month June Day 4 Year 2002
3. Time of Death: 6:20 AM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-12-0974
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 19 1922
9. Birthplace (State or Foreign Country): Georgia

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street and Number: 2601 Queen Anne Road
10f. Zip Code: 21216
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 years
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Alonzo Coates
18. Mother's Name (First, Middle, Maiden Surname): Bertha Hanes

19a. Informant's Name/Relationship (Type, Print): Carolyn E. Booker/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14662 Fieldstone Drive Sara Toga, CA 95070

20a. Method of Disposition: ☒ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: June 11, 2002
20c. Location - City or Town, State: Balto., MD

21. Signature of Funeral Service Licensee: Ernest R. Tenyer
22. Name and Address of Facility: Rutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, MD 21216

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ 1 **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): June 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sinai Hospital of Baltimore 2401 West Belvedere Avenue Baltimore, MD 21215

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: Brenda B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #12 per FHG808 6/12/02 EW

# Certificate of Death

Reg. No. 2002 18875

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Jasper, Faulk | 06 / 08 / 02 | 13:55 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis, MD | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 243-26-1773 | 1 [X] M 2 [ ] F | 76 Yrs. | | | 03 02 26 | N.C. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Annapolis | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3432 Narragansett Ave | 21403 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | 1 yr | Fireman | City of Baltimore |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Wilmer Faulk | Mae Floyd |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Deborah Faulk-Wife | 3432 Narragansett Ave, Annapolis, Md 21403 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Fairmont Cemetery | 6/16/02 | Fairmont, NC |

21. Signature of Funeral Service Licensee: John March

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

**Permit.** Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Renal Cell Carcinoma | 6 weeks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No | 24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No |
|---|---|

| 25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No | 26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |
|---|---|

| 27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Sara C. Horton MD | D0057985 | 06/09/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SARA C. HORTON 600 RIDGELY AVE #231 ANNAPOLIS, MD 21401

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1077

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | Bonnie B Jones |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene — 2002 18876

# Certificate of Death

Reg. No.

AMEND ITEM #10c PER FH G808 6/12/02 JH

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edward Francis

2. Date of Death — Month: June; Dey: 8; Year: 2002

3. Time of Death: 7:35pm

4a. Facility Name (If not institution, give street and number): Caton Manor, 3330 Wilkins Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-28-1337

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth (Month, Day, Year): 06-04-1929

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: ~~Glen Burnie~~ BALTIMORE

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 630 Wildwood Pkwy

10f. Zip Code: 21229

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No — If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ ~~No~~ Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed) — Elementary/Secondery (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Transportation

17. Father's Neme (First, Middle, Lest): Richard Francis

18. Mother's Name (First, Middle, Maiden Surname): Beulah Savage

19a. Informant's Name/Relationship (Type, Print): Edwina R. Dorsey (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 630 Wildwood Pkwy Balto. MD. 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest

Date: 6/14/02

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene

22. Name and Address of Facility: Vaughn C. Greene Funeral Ser 6151 Balto. Nat'l P.Ke Balto. MD. 21229

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicatins that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. Asperation Pneumonia — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last:

b. Due to (or es e consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitas

Cerebral Vascular Accident

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and plece, and due to the ceuse(s) and manner as steted. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: ▶ Attending Physician

29c. License number: D53642

29d. Date signed (Month, Dey, Year): June 10 2002

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): XIAO ZHEN 3007 E Northern Parkway Baltimore 21214

**State Registrar**

31. Dete filed (Month, Dey, Year): JUN 12 2002

32. Registrer's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name: Francis, Edward

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18877

**Physician /Medical Examiner**

**Funeral Director**

1. Decedent's Name *(First, Middle, Last)*: DOROTHY M. FARLOW
2. Date of Death Month / Day / Year: JUNE 10 2002
3. Time of Death: 11:45 AM
4a. Facility Name *(If not institution, give street and number)*: UNIVERSITY OF MARYLAND HOSPITAL SYSTEM
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A.
5. Social Security Number: 219-34-4570
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUGUST 2, 1934
9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8459 WATER OAK RD.
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE
16b. Kind of Business/Industry: HOME.

17. Father's Name *(First, Middle, Last)*: UNKNOWN
18. Mother's Name *(First, Middle, Maiden Surname)*: UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: ANNAMARIE ARROWOOD
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8459 WATER OAK RD. BALTO. MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: PARKWOOD CEMETERY
Date: 6/13/02
20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: ▶ Paul M. Stella
22. Name and Address of Facility: HARTLEY MILLER — STELLA FUNERAL HOME CH TO, 7527 HARFORD RD. BALTO. MD 21234

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier: ▶ KG Hairston MD
29c. License number: G 15887
29d. Date signed *(Month, Day, Year)*: 6/10/02.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KRISTER G. HAIRSTON MD. 22 South Greene ST. Balt. MD 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: JUN 12 2002
32. Registrar's Signature: ▶ B. Sparks

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18878

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Flora | Marie | Gunsolley | June | 11 | 2002 | 5:15 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Heartlands of Severna Park | Severna Park | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 397-18-3967 | 1☐M 2☒F | 81 Yrs. | | | | | Nov. 20, 1920 | Colorado |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Riva | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 363 Westbury Drive | 21140 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Teacher | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Ward Beecher Cart | Clara Driscoll |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John Cart Gunsolley (Son) | 363 Westbury Drive, Riva, MD 21140 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Crematory | 06/12/2002 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Squamous Cell Carcinoma - Mandible

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

metastatic carcinoma

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Assisted Living

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D41955 | 6-12-02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rebecca Bon MD 479 Jumpers Hole Rd #304 Severna Park MD 21146

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 ie marked other then "neturel, or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18879

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| AUDREY T. GREGG | JUNE 7 2002 | 7:52 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2703 SPELMAN RD APT. B-1 | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-34-9933 | 1☐ M 2☒ F | 64 Yrs. | | | 6-25-1937 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2703 SPELMAN RD APT. B-1 | 21225 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | COOK | RESTAURANT |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JAMES EVANS | MARY EVANS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOHN LEGGE (SON) | 2703 SPELMAN RD BALTIMORE MD 21225 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | MT. ZION | 12JUNE2002 | BALTO. CO. MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| E.N.WALKER JR | ESTEP BROS. FUNERAL SERVICE P.A. 1300 EUTAW PLACE BALTO. MD 21217 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cirrhosis with Ascites — Two years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Alcoholism — Two years

Due to (or as a consequence of):

c. Coagulopathy — Two years

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown | 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown | 1☐ Yes 2☑ No | 1☐ Yes 2☑ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D25373 | June 10, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JERRY HUNT, MD. 2900 S. HANOVER ST, BALTIMORE, MD 21225

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18880

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): **Thomas C Greenleaf**

2. Date of Death Month Day Year: Jun 1, 2002

3. Time of Death: 10:45 PM

4a. Facility Name (If not institution, give street and number): 725 E. 21 Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 212-30-4223

6. Sex: X 1 M 2 F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 18, 1933

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 Yes X 2 No

10e. Street and Number: 9445 Merryrest Rd

10f. Zip Code: 21045

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married X 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? X 1 Yes 2 No If Yes, Give Year or Dates: 1953 1961

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes X 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: D and G trucking

17. Father's Name (First, Middle, Last): Richard Greenleaf

18. Mother's Name (First, Middle, Maiden Surname): Eliza Greenleaf

19a. Informant's Name/Relationship (Type, Print): Ellen Greenleaf Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9445 Merryrest Rd Columbia, Maryland 21045

20a. Method of Disposition: X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Veterans Cemetery

Date: 06/11/02

20c. Location - City or Town, State: Owings Mills , MD

21. Signature of Funeral Service Licensee: Lloyd M. Estep

22. Name and Address of Facility: Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, Md. 21217

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypertension — Approximate Interval: 10y

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hyperlipidemia — Approximate Interval: 10y

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes X 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? X 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? X 1 Yes 2 No

25. Was case referred to medical examiner? X 1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence X 6 Other (Specify)

27. Manner of Death: X 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): X 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gwynn Schoonmaker MD

29c. License number: 13143

29d. Date signed (Month, Day, Year): 6/7/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gwynn Schoonmaker VAMC 10 North Green Street Baltimore Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002

32. Registrar's Signature: Brenda B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

Amend Items 28a,b,f per Dr.06/11/02dhb,G808 (25,27,28f) (For State Registrar)

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

2002 13881 (Reg. No.)

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANNetta I. GROtt
2. Date of Death: Month May Day 27 Year 2002
3. Time of Death: 8:48 AM
4a. Facility Name (If not institution, give street and number): Northwest HOSPital
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore County

**Funeral Director**

5. Social Security Number: 216-05-9010
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month/Day/Year): NOV 12 1917
9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9012 ALLENSWOOD ROAD
10f. Zip Code: 21133
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): LOUIS ISRAELSON
18. Mother's Name (First, Middle, Maiden Surname): SARAH SINDLER

19a. Informant's Name/Relationship (Type, Print): MS. SUSAN GROTT/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12097 LONG LAKE DRIVE OWINGS MILLS, MD.21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory, or other place): ANSHE EMUNAH-A CHAIM CONGREGATION
Date: 5/28/2002
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD.21208

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Pneumonia
Due to (or as a consequence of):
b. Respiratory failure
Due to (or as a consequence of):
c. Renal failure
Due to (or as a consequence of):
d. Compound fracture left thoracic 5

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

CERTIFICATE APPROVED BY MEDICAL EXAMINER

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive cardiomyopathy
Coronary Artery Disease
Hypertension

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes ~~2☐ No~~
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): May 16, 2002
28b. Time of Injury: 5:00PM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Pt. fell while cutting flowers
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 9012 Allenswood Road, Randallstown, MD

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] (MD)
29c. License number: D37035
29d. Date signed (Month, Day, Year): May 27, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan Lefkowitz, M.D. 5400 OLD COUNTY Rd. Suite 205, Randallstown, Md 21133

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

02-3073-005
B.K.S
THOMAS HAWKE

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061902:ITEMS#23a,27 per ME 6808 ss

# Certificate of Death

Reg. No. 2002 18882

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Thomas Patrick Hawke | JUNE 8, 2002 | 0902 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| NORTHWEST HOSPITAL CENTER | RANDALLSTOWN | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 124-64-1801 | XX M 2 F | 22 Yrs. | | | 04/13/1980 | New York |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Owings Mills | 1 Yes 2 XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4812 Simonds Drive | 21117 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| XX Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 XX No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Sales Consultant | Marketing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Thomas John Hawke | Kathleen Anne McTygue |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Kathleen Anne McTygue/mother | 4812 Simonds Drive Owings Mills, MD 21117 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Hilltop Svc. Corp. | 06/12/2002 | Towson, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] M0112 | Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS SEPSIS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 Yes 2 ☑ No 3 Probably 4 Unknown | 1 ☑ Yes 2 No | 1 ☑ Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 No | Hospital: 1 Inpatient 2 XX ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☑ X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ J Pestaner M.D. | O.C.M.E | JUNE 9, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

I ok'ed # .

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18883

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| ALBERT | HOFFMAN | JUNE 8, 2002 | 5:15 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 4000 N. CHARLES STREET #506 | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-18-3458 | 1 X M 2 ☐ F | 78 Yrs. | | | AUG. 13, 1923 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4000 N. CHARLES STREET #506 | 21218 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WWII | 1 ☐ Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | SALESMAN | RETAIL |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| NATHAN | HOFFMAN | SOPHIE | SCHINLER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| HETLEN HOFFMAN / WIFE | 4000 N. CHARLES STREET #506 - BALTIMORE, MD 21218 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | RADOMER VEREIN CEM. | 6/10/2002 | ROSEDALE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. AORTIC ANEURYSM

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D42827 | 6/10/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20 CROSSROADS DR. SUITE 14 OWINGS MILLS, MD 21117

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | [signature] |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2002 18884

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| SOCRATES INMAN | 06-05-2002 | 9:30 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| VILLA SAINT MICHEALS | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 241-16-9819 | 1☑M 2☐F | 88 Yrs. | | | 05-17-1914 | NC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3113 PRESBURY STREET | 21217 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☑Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12TH GRADE | N/A | CUSTODIAN | BETH. STEEL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| ALFORD THOMPSON | UK EMMALINE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| SHEILA JONES / DAUGHTER | 1100 VOLOS CT. BELAIR MD 21015 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify) | GARRISON FOREST | 6-12-02 | OWINGS MILLS, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ David C L | VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Bilateral Pneumonia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Cerebro vascular Accident

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Anil Uberai MD | D26748 | 6/6/2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANIL UBEROI MD 4419 FALLS RD BALTOMD 21211

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM #7&23a&B PER FH&phy g808 6/12/02 JH

2002 | 8885
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| CARRIE THELMA JOHNSTON | JUNE 9, 2002 | 1530 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Spa Creek Center | Annapolis | Anne Arundel Co. |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212 20 8230 | 1☐M 2☒F | 79 ~~78~~ Yrs. | | | 5-18-23 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Anne Arundel Co. | Arnold | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 474 Lakeside Drive | 21012 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: X | 1☐Yes 2☒No X Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | 0 | Waitress | Tavern |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Graham E. Joyner | Ida E. Brown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Linda C. Smith (Daughter) | 6 Bailiffs Court # 301, Timonium, Md. 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Meadowridge Memorial Park | 6/13/2002 | Elkridge, Md. |

21. Signature of Funeral Service Licensee: George M. Hampton Jr

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CARDIAC ARRHYTHMIA ~~CHRONIC RENAL FAILURE~~ | MINUTES |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. CHRONIC RENAL FAILURE | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE, VERTEBRAL OSTEOMYELITIS

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Brian C. Wallace MD | D31136 | JUNE 9, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN C. WALLACE MD, 35 MILKSHAKE LANE, ANNAPOLIS, MD 21403

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | Jennifer B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18886

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| GLORIA | JONES | JUNE 9 2002 | 9:00 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GOOD SAMARITAN HOSPITAL | BALTIMORE, MD. | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-52-7019 | 1 ☐ M 2 ☒ F | 53 Yrs. | | | 09-17-1948 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | BALTIMORE | 1 ☒ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4006 Biddison Lane | 21206 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9th | | HOUSEKEEPING | CLEANING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| HORACE LEE JONES | LUCY LEE HUGGINS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| KIMBERLY JONES (DAUGHTER) | 1304 CROFTON ROAD · BALTO, MD · 21239 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | METRO CREMATORY | 6/11/02 | BALTIMORE, MD |

21. Signature of Funeral Service Licensee — KLO 1085

22. Name and Address of Facility: CREMATION SERVICES, P.A. 5151 BALTO NAT'L PIKE · BALTO, MD · 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. INTERSTITIAL LUNG DISEASE | |
| Due to (or as a consequence of): | b. AIDS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. END STAGE MENTAL DISEASE | |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HIV NEPHROPATHY

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD. | RES 000 | JUNE 9, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR HINA SAHI, GOOD SAMARITAN HOSPITAL, 5601, LOCH RAVEN BOULEVARD, BALTIMORE, MD, 21239

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18887

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Elizabeth Amelia Kraemer | June 8, 2002 | 10:00 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 6907 Brentwood Avenue | Dundalk | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-01-6570 | 1☐ M 2☒ F | 92 Yrs. | | | Nov. 19, 1909 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Dundalk | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6907 Brentwood Avenue | 21222 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 2 Years | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Richard Reinhold | Helen Wissasek |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard E. Kraemer (Son) | 6907 Brentwood Ave. Dundalk, Maryland 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Oak Lawn Cemetery | 6/12/2002 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Stephanie Massey | Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive Heart Failure | 2/02 |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Valvular Heart Disease | ~2 years |
| | Due to (or as a consequence of): c. A.S.C.V.D. | ~10 years |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Arthritis, Peripheral Vascular disease Hypertension

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Dana S Simpkins | D535170 | 6/10/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dana S. Simpkins, 808-810 S. CONKLING ST. Balto MD 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | Barbara B Sparks |

DHMH 17 Rev 1/2001

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**Division of Vital Records, P.O. Box 68760,**

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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18888

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| IRVING | R. | LOWITZ | JUNE 8, 2002 | 5:50 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 7 SLADE AVENUE #717 | BALTIMORE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-42-3003 | 1 X M 2 F | 85 Yrs. | | | JAN 29 1917 | NY. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7 SLADE AVE # 717 | 21208 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 X Widowed 4 Divorced | 1 X Yes 2 No If Yes, Give Year or Dates: WWII - NAVY | 1 Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) 5 + | SURGEON | MEDICAL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| SAMUEL LOWITZ | KATIE SCHMUCKLER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ROBIN A. LOWITZ/DAUGHTER | 3052 HUNTING RIDGE DRIVE OWINGS MILLS, MD. 21117 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | BALTIMORE HEBREW | JUNE 11 2002 | REISTERSTOWN ,MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Arteriosclerotic Heart Disease | 2 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? 1 Yes 2 X No | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
|---|---|

| 25. Was case referred to medical examiner? 1 Yes 2 X No | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home X Residence 6 Other (Specify) |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] Leonard Kotz MD | D 06322 | June 10, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LEONARD KOTZ, MD 1838 Greene Tree Road Baltimore Md 21208

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | [signature] D Sparks |

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Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18889

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gus Allen McLaughlin
2. Date of Death (Month, Day, Year): June 10, 2002
3. Time of Death: 9:40A M
4a. Facility Name (If not institution, give street and number): St. Agnes Nursing Home
4b. City, Town, or Location of Death:
4c. County of Death:

**Funeral Director**

5. Social Security Number: 246-38-7464
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 17, 1928
9. Birthplace (State or Foreign Country): NC

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Balto.
10c. City, Town or Location: Woodlawn
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1431 Kirkwood Rd.
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4 yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housing Manager
16b. Kind of Business/Industry: City of Balto.

17. Father's Name (First, Middle, Last): Charles G. McLaughlin
18. Mother's Name (First, Middle, Maiden Surname): Mamie I. Carver
19a. Informant's Name/Relationship (Type, Print): Phyllis W. Green (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1431 Kirkwood Rd. Woodlawn MD. 21207

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Cemetery
Date: 6/15/02
20c. Location - City or Town, State: Baltimore, MD.

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name and Address of Facility: Vaughn C Greene Funeral Svc. 5151 Balto. Nat'l Pike Balto. MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Diabetic kidney Disease
Due to (or as a consequence of):
b. Diabetes mellitus
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death: years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Organic Brain Syndrome

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Alejandro Mesia MD
29c. License number: D0008780
29d. Date signed (Month, Day, Year): 6/12/2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALEJANDRO MESIA. MD 405 Frederick Rd. Baltimore MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: ▶ [signature]

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #8 PER FH G808 6/12/02 J **Certificate of Death**

Reg. No. 2002 18890

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Arthur Morant Jr | JUNE 6 2002 | 2:34 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SINAI HOSPITAL OF BALTIMORE | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 248-60-2884 | 1 ☐ M 2 ☐ F | 62 Yrs. | | | 6-28-39 | SC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1 ☑ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3645 Wabash Ave | 21215 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☑ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Facilty Manager | Healthcare |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Arthur Morant Sr. | Mary Collins |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Shirley L. Morant (wife) | 3645 Wabash Ave Balto. MD. 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Maryland National | 6/12/02 | Laurel, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Vaughn C Greene | Vaughn C Greene Funeral Svc. 5151 Balto. Nat'l P.Ke Balto MD. 21229 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HASCVD — Approximate Interval Between Onset and Death: Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. HYPERTENSUM — unknown

Due to (or as a consequence of):

c. Diabetes Mellitus — unknown

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

| 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No | 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No |
|---|---|

| 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |
|---|---|

| 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D25379 | JUNE 6, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STEVEN L. JOFFE, M.D. 2401 W. Belvedere Ave. Baltimore, MD 21215

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Morant, Arthur

10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18891

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jerry Montgomery
2. Date of Death: Month June Day 4 Year 2002
3. Time of Death: 0150 AM
4a. Facility Name (If not institution, give street and number): University of Maryland Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 219-40-3927
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/25/1945
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: VA
10b. County: PRINCE WILLIAM
10c. City, Town or Location: LAKE RIDGE
10d. Inside City Limits: [X] Yes 2 [ ] No
10e. Street and Number: 12293 GRANADA WAY
10f. Zip Code: 22192
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WRITER
16b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Name (First, Middle, Last): WILLIAM MONTGOMERY
18. Mother's Name (First, Middle, Maiden Surname): FLORA MAE GRIFFEN

19a. Informant's Name/Relationship (Type, Print): JANICE MONTGOMERY / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PMB#303, 12471 DILLINGHAM SQUARE, LAKE RIDGE, VA 22192

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. BENEDICT'S CEM.
Date: 06/07/2002
20c. Location - City or Town, State: RICHMOND, NH

21. Signature of Funeral Service Licensee: DANIEL SIMONS
22. Name and Address of Facility: MARYLAND MORTUARY SUPPORT PO BOX 2938, BALTIMORE, MD 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Liver Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Hepatitis C
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: 13772
29d. Date signed (Month, Day, Year): June 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ben Bridges, University of Maryland, 22 South Greene, Baltimore, Maryland

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: Georgia B Sparks

DHMH 17 Rev 1/2001

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Unknown 02-155
02-2731-033
crn
David J. Mingay 1- For State Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18892

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DAVID JOHN MINGAY

2. Date of Death: Month May, Day 26, Year 2002

3. Time of Death: 3:40 P M

4a. Facility Name (If not institution, give street and number): Mile Post 118.1, Track #3, near Lemon Bridge Road

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 356-62-3758

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 12, 1955

9. Birthplace (State or Foreign Country): ENGLAND

Usual Residence of Decedent

10a. State: MD

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: SUITLAND

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2312 EWING AVE, #2

10f. Zip Code: 20746

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RESEARCH PYCHOLOGIST

16b. Kind of Business/Industry: US CENSUS BUREAU

17. Father's Name (First, Middle, Last): KENNETH ROY MINGAY

18. Mother's Name (First, Middle, Maiden Surname): BARBARA MARY JOHNSON

19a. Informant's Name/Relationship (Type, Print): BARBARA M. MINGAY / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 58 WELHOLME AVE., GRIMSBY, N.E. LINCOLNSHIRE, DN320PN

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SCARTHO ROAD CEM.

Date: 06/18/2002

20c. Location - City or Town, State: GRIMSBY, N.E.LINCOLNSHIRE

21. Signature of Funeral Service Licensee: DANIEL S. SIMONS

22. Name and Address of Facility: MARYLAND MORTUARY SUPPORT PO BOX 2938, BALTIMORE, MD 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 5/26/02

28b. Time of Injury: 3:10 PM

28c. Injury at Work? 1 [ ] Yes 2 [✓] No

28d. Describe how injury occurred: Subject jumped in front of Train

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Train Tracks

28f. Location (Street and Number or Rural Route Number, City or Town, State): Mile Post 118.1 Bowie, Maryland.

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): May 27, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002

32. Registrar's Signature

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ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18893

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Bernard | Manilla | June 8, 2002 | 1:03 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Frederick Mem. Hosp. | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 204-14-8489 | 1☐M 2☐F | 76 Yrs. | | | July 14, 1925 | PA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| PA | Mercer | Sharon | ☒ Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 765 Fisher Hill | 16146 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | Customer Service Rep. | Westinghouse |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Louis Manilla | Maria DePasquale |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary E. Manilla/Wife | 765 Fisher Hill Sharon PA 16146 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☒Removel from State 4☐Donation 5☐Other (Specify) | St Rose Cem. | June 12, 2002 | Hermitage, PA |

21. Signature of Funeral Service Licensee ▶ Victor Doda

22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Ave. Baltimore MD 21230

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease — years

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension Diabetes Atrial Fibrilation

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D35164 | June 8, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Patrick Jr, MD 1080 W. Patrick St Frederick, MD 21703

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18894

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Dennis | Norton | June 6 2002 | 2:30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Baltimore VA Medical Center | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 381-62-8044 | 1☑M 2☐F | 47 Yrs. | | | 08-18-1954 | MI |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| WEST VA | | DELRAY | 1☐Yes 2☑No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| P. O. BOX 25 | 26755 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☑Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 TH GRADE | N/A | IRON WORKER | CONSTRUCTION |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| THOMAS NORTON | JOYCE WRIGHT |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| LISA NORTON \| WIFE | P.O. BOX 25, DELRAY W.VA 26714 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | METRO CREMATORY | 06-08-02 | BALTIMORE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | CREMATION SERVICES 5151 BALTO. NATL PIKE, BALTO. MD - 21229 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Lymphoma | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Salma Jabbour Medical Resident | P15765 | June 6 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Salma Jabbour 22 South Greene Street Baltimore MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then 'natural', or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18895

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Dollie E. Nobles
2. Date of Deeth: Month 6 Day 10 Year 2002
3. Time of Death: 4:05 P.M.

4a Facility Neme *(If not institution, give street and number)*: Brightwood Center
4b. City, Town, or Location of Death: Lutherville
4c. County of Death: Balto

**Funeral Director**

5. Social Security Number: 226-34-0530
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 1-30-1921
9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3962 Penhurst Avenue
10f. Zip Code: 21215
10g. Citizen of What Country?: U S A

11. Marifel Stafus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 2 years
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor
16b. Kind of Business/Industry: Stewarts Dept Store

17. Father's Name *(First, Middle, Last)*: John Yates
18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Dixon

19a. Informant's Name/Relationship *(Type, Print)*: Joe D. Nobles, Sr - Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3962 Penhurst Avenue Balto, Md 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Druid Ridge Cemetery
Date: 6-14-02
20c. Location - City or Town, State: Balto, Md

21. Signature of Funeral Service Licensee: Lola March
22. Name and Address of Facility: March F/H West 4300 Wabash Avenue Balto, Md 2121

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pulmary embolus — Unknown

Due to (or as a consequence of):

Sequentiatly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Dementia; Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and fitle of certifier: MD
29c. License number: D27564
29d. Date signed *(Month, Day, Year)*: 6/11/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan Hettleman 1838 Green Tree Rd #300

**State Registrar**

31. Dete filed *(Month, Day, Year)*: JUN 12 2002
32. Registrar's Signature

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** Tha law requiras thet the death certificata be executed within 24 hours after death.
**To the Funeral Director:** After this certificata has been signed by the attending physician and completely filled in by tha funerel diractor, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

ADH
UNKNOWN 02-171
02-2980-510
STEVEN S. NOLL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 062602:ITEMS#23a,27,28a-f per ME G808 ss

# Certificate of Death

Reg. No. 2002 18896

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Steven Scott Noll
2. Date of Death: Month JUNE Day 5, Year 2002
3. Time of Death: 1130 AM
4a. Facility Name (If not institution, give street and number): 3600 PULASKI HWY.
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 219-56-5973
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 48 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 30, 1953
9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore County
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9309 Perglen Road
10f. Zip Code: 21236
10g. Citizen of What Country?: United States of America

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Carpentry

17. Father's Name (First, Middle, Last): Joseph Noll
18. Mother's Name (First, Middle, Maiden Surname): Betty Jane Roberts

19a. Informant's Name/Relationship (Type, Print): Ms. Bylle Jane Hoelter (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7231 Harbor Lane Columbia, Maryland 21045

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gd.
Date: 6/11/2002
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr.
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC AND COCAINE INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined
28a. Date of Injury (Month, Day Year): 6-5-02
28b. Time of Injury: Unknown M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Motel
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3600 Pulaski Hwy., Baltimore, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: OCME
29d. Date signed (Month, Day, Year): JUNE 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Alton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 off pend.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18897

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Dete of Deeth Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|
| Estelle | Parker | June | 9 | 2002 | 8:50am |

| 4e Feciity Neme (If not institution, give street end number) | 4b. City, Town, or Location of Death | 4c. County of Deeth |
|---|---|---|
| Mariner Nursing Home | Glen Burnie | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Dey, Yeer) | 9. Birthplace (Stete or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 247-44-5374 | 1☐ M 2☒ F XX | 84 Yrs. | | | | | 01 29 18 | SC |

Usuel Residence of Decedent

| 10a. Stete | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Hanover | 1☐ Yes 2☒ No |

| 10e. Street end Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1304 Strawberry Lane | 21076 | U.S.A. |

| 11. Maritel Status | 12. Wes Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Merried 2☐ Married XX☒ Widowed 4☐ Divorced | 1☐ Yes 2☐ No If Yes, Give Year or Dates: XX | 1☐ Yes 2☒ No XX Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grede completed) | | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 8th grade | na | Presser | American Cleaners |

| 17. Father's Neme (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Sligh | Elivia Swindler |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Donzella Parker Bert-Daughter | 1304 Strawberry Lane, Hanover, Md 21076 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Garrison Forest Vet | 6/14/02 | Owings Mills, Md |

21. Signature of Funeral Service Licensee: Lala March

22. Name and Address of Feciility: March F/H West, 4300 Wabash Ave, Baltimore, Md 21215

**Physician /Medical Examiner**

33. Part1. Enter the dis-ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Ceuse (Final diseese or condition resulting in death) | e. Cirrhosis of liver | years |
| | Due to (or as e consequence of): | |
| Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last | b. | |
| | Due to (or es e consequence of): | |
| | c. | |
| | Due to (or es e consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

**23b. Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28e. Date of Injury (Month, Dey Year) | 28b. Time of Injury M | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Nature 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined | | | 1☐ Yes 2☐ No | |
| | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Yeer) |
|---|---|---|
| Signature | D0040491 | 6-11-02 |

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
800 N Hammonds Ferry Rd Linthicum Md 21090

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrer's Signature |
|---|---|
| JUN 12 2002 | Signature |

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours efter death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

# Certificate of Death

Reg. No. 2002 18898

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| EVELYN | L. | PEDDICORD | JUNE 09 2002 | 10:08 PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GENESIS ELDERCARE SEVERNA PARK | SEVERNA PARK | ANNE ARUNDEL CO. |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-01-9337 | 1☐ M 2☒ F | 83 Yrs. | | | Nov. 12 1918 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Anne Arundel Co. | Severna Park | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 556 West Drive | 21146 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | 0 | Cafeteria | Anne Arundel Co. Board of Education |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| unknown | Townsend | Florence | Mooney |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Charles Wayne Martin (Son) | 556 West Drive, Severna Park, Md. 21146 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Pine Grove Cemetery | 6/12/2002 | Rayville, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| John F. Collins | McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. respiratory failure — hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. chronic obstructive pulmonary disease — years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dementia, atrial fibrillation, right lung mass

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D4195J | 6-10-02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rebecca Eden MD 479 Jumpers Hole Rd #304 Severna Park MD 21146

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

CPM
02-3050-510
JAMES POWELL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

2002 16899 Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JAMES M. POWELL | JUNE 07, 2002 | 18:01 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| UNIVERSITY OF MARYLAND SHOCK TRAUMA | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-16-0878 | 1☒M 2☐F | 82 Yrs. | | | JUNE 3 1920 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 912 LYNDHURST AVENUE | 21229 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 44/46 | 1☐Yes ☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12yrs | | STATIONARY ENGINEER | LIBERTY MEDICAL CNTR |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JAMES F POWELL | VERDELLA SMITH |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Anthony E. Powell/Son | 6808 Brompton Rd., Baltimore, Maryland 21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | BALTIMORE NATIONAL | 06-13-02 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Charles E. Powell | WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MULTIPLE INJURIES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) 6/7/02

28b. Time of Injury 2:23 P M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred Pedestrian struck by vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROAD

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3900 BLOCK EDMONDSON AVE

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | O.C.M.E. | JUNE 8, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 18 2002 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Physician/Medical Examiner**

V

6X1

ADH
MARY PERRY
02-3082-031

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

2002 18900

1- For State Registrar AMEND ITEM #18 PER FH G808 6/12/02 JH

# Certificate of Death

Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| MARY | G. | PERRY | JUNE | 9, | 2002 | 0742 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 11215 SEVEN LOCKS DRIVE | POTOMAC | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 082-22-3751 | 1☐M 2☒F | 86 Yrs. | | | MAR 19 1916 | NY. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | MONTGOMERY | POTOMAC | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8249 BUCKSPARK LANE WEST | 20854 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | JUDGE'S SECRETARY | FAMILY COURT-STATE OF NEW YORK |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| LOUIS GELLER | ~~RUTH~~ REBECCA WALDMAN ~~(UNKNOWN)~~ |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. SUSAN ZACHARIA/DAUGHTER | 8249 BUCKSPARK LANE WEST POTOMAC, MD. 20854 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory, or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify) | STAR OF DAVID | 6/12/2002 | N. LAUDERDALE, FL. |

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Arteriosclerotic Cardiovascular Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| If FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| ~~1~~☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | OCME | JUNE 10, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | Barbara B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

02-3098-003
B.K.S
UNKNOWN 02-180
VALERIE R. PAGE

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

For State Registrar

Reg. No. 2002 18901

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Valerie Page

2. Date of Death (Month, Day, Year): june 10, 2002

3. Time of Death: 0220 A M

4a. Facility Name (If not institution, give street and number): 1752 CHURCH STREET

4b. City, Town, or Location of Death: BROOKLYN PARK

4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 214-88-0391

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 38 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 5, 1963

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 849 Glade Ct.

10f. Zip Code: 21225

10g. Citizen of What Country?: USA

**To Be Completed by Funeral Director**

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HouseKeeper

16b. Kind of Business/Industry: Private Firm

17. Father's Name (First, Middle, Last): Earl A. Robinson Sr.

18. Mother's Name (First, Middle, Maiden Surname): Vernice Watson

19a. Informant's Name/Relationship (Type, Print): Ms. Corina McNeil (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1115 Punjab Drive Balto. Md. 21221

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion

Date: 6/17/2002

20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 6/10/02

28b. Time of Injury: UNK M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: Subject struck and run over by vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Parking lot

28f. Location (Street and Number or Rural Route Number, City or Town, State): 900 Church St. Brooklyn Park, MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Clarke Locke MD

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): JUNE 10, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. CLARKE LOCKE MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002

32. Registrar's Signature:

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18902

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gloria Poole

2. Date of Death: Month JUNE Day 08 Year 2002

3. Time of Death: 8:05A M

4a. Facility Name (If not institution, give street and number): MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE City

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-90-9792

6. Sex: 1☐M 2☒F

7. Age (In/yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 30, 1961

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 6204 Falkirk Rd.

10f. Zip Code: 21239

10g. Citizen of What Country? USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Leroy

18. Mother's Name (First, Middle, Maiden Surname): Willie Mae Green

19a. Informant's Name/Relationship (Type, Print): Ms. Bernadine Poole (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6204 Falkirk Rd. Balto. Md. 21239

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion

Date: 6/13/2002

20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c. Acquired Immune Deficiency Syndrome

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one)

Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 89394

29d. Date signed (Month, Day, Year): 06-08-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carol Baltazar M.D. C/O Maryland General Hospital

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002

32. Registrar's Signature:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Gloria Poole

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18903

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): VERNON ROBINSON
2. Date of Death Month JUNE Day 9 Year 2002
3. Time of Death 3:11 P.M
4a. Facility Name (If not institution, give street and number): 1837 NORTH REGISTER ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 217-18-9418
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 3, 1923
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1837 N. REGISTER ST.
10f. Zip Code: 21213
10g. Citizen of What Country? USA

**To Be Completed by Funeral Director**

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: HEDWIN'S PLASTIC INC.
17. Father's Name (First, Middle, Last): NATHAN ROWE
18. Mother's Name (First, Middle, Maiden Surname): BLANCHE ROBINSON
19a. Informant's Name/Relationship (Type, Print): CLEORIA ROBINSON (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1837 N. REGISTER ST, BALTO. MD. 21213
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DUSHELL CEMETERY Date: 06-15-02
20c. Location - City or Town, State: BALTIMORE, MARYLAND
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Metastatic lung cancer — Approximate Interval Between Onset and Death: unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Residence
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E. Tso MD.
29c. License number: D24170
29d. Date signed (Month, Day, Year): June 10, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E. Tso MD Richey Hospice 820 N. Eutaw St Baltimore, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3:11P June 9, 2002 Vernon S Robinson

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEMS#20b,c per fh G808 061702 ss

# Certificate of Death

Reg. No 2002 18904

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| DENA | DENISE | RICHARDS | JUNE 9 2002 | 5:45 P.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 618 NORTH MONTFORD | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-86-8833 | 1☐ M 2☒ F | 36 Yrs. | | | OCT. 01, 1965 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE CITY | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 201 NORTH CAREY ST. | 21223 | USA. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11TH GRADE | | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| DELROY | RICHARDS | GWENDOLYN | HUNTLEY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| KAREN HENDERSON (SISTER) | 633 N. CARROLLTON AVE., BALTO. MD. 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | MT. ZION CEMETERY ~~MD. NATIONAL CEME.~~ | 6-14-02 ~~6-13-02~~ | Lansdowne ~~LAUREL, MARYLAND~~ |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC BREAST CANCER | UNKNOWN |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☒ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOME HOSPICE

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D0026327 | 6-11-2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOUGLAS D. ROSS, 6114 CAMPFIRE, COLUMBIA, MD 21045

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 18 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18905

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| DORIS CORNELIA ROBINSON | June 7 2002 | 8:00p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1700 McCulloh Street | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-30-4626 | 1☐M 2☒F | 66 Yrs. | | | OCT 06 1935 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1700 McCulloh Street | 21217 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | | HOME PROVIDER | PRIVATE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| GEORGE A. ROBINSON | FLORENCE L. PAYNE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Renee Phillips/Niece | 722 N. Carrollton Avenue, Baltimore, Md. 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | ST.LUKE U.M.C CEM. | 06-14-02 | REISTERSTOWN, MD |

21. Signature of Funeral Service Licensee ▶ Charles B. Powell

22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. (R) sided Heart Failure

Due to (or as a consequence of):
b. HTN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. COPD

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Depression
Reflux

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D46250 | 6/11/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOPHIA ROBINSON, MD
922 W. North Ave. Baltimore MD 21217

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | Barbara B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18906

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Florence C. Roe

2. Date of Death: Month 6 Day 6 Year 2002

3. Time of Death: 1924 M

4a. Facility Name (If not institution, give street and number): 300 Raleigh Road

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: AA.

**Funeral Director**

5. Social Security Number: 216-18-0812

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): 4-18-1917

9. Birthplace (State or Foreign Country): Va

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Md

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 300 Raleigh Road

10f. Zip Code: 21060

10g. Citizen of What Country? U S A

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th grade

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian

16b. Kind of Business/Industry: State of Md

17. Father's Name (First, Middle, Last): Earnest Mason

18. Mother's Name (First, Middle, Maiden Surname): Mamie Thomas

19a. Informant's Name/Relationship (Type, Print): Barbara Parker - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1343 Chapleview Drive Odenton, Md 21113

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 6-11-2002

20c. Location - City or Town, State: Anne Arundel Co, Md

21. Signature of Funeral Service Licensee: Glenne A. Thompson

22. Name and Address of Facility: March F/H West 4300 Wabash Avenue Balto, Md 21215

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ___

Due to (or as a consequence of):

d. ___

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ___ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William P. Jones Deputy MD

29c. License number: D060054

29d. Date signed (Month, Day, Year): 6/10/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18907

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Bernice | G. | Spence | JUNE 7 2002 | 0300 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SINAI HOSPITAL OF BALTIMORE | BALTIMORE | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-12-8659 | 1 ☐ M 2 ☒ F | 80 Yrs. | | | 05 21 22 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | ☒ 1 Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3615 Fords Lane Apt 509 | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11th grade | na | Home Health Aid | Private |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Paul Pinkney | Annie Vaughn |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Adrianne Vaughn-Niece | 44 Maple Street, Yonkers, NY 10701 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Baltimore National | 6/14/02 | Baltimore, Md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Kala March | March F/H West 4300 Wabash Ave, Baltimore Md 21215 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CARDIOGENIC SHOCK

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

| 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No | 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No |
|---|---|
| | |

| 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |
|---|---|
| | |

| 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | | | | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Alden Peoples, MD | D50693 | JUNE 7, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALDEN G. PEOPLES, MD 2401 W. BELVEDERE AVE, BALTIMORE, MD 21215

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | ▶ Brenda B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Bernice Spence

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18908

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lawrence E. Spencer Sr.
2. Dete of Deeth: Month June, Dey 8, Year 2002
3. Time of Death: 8:00am
4e Feciity Neme (If not institution, give street and number): Gilchrist Nursing Home
4b. City, Town, or Location of Deeth: Towson
4c. County of Deeth: Baltimore

**Funeral Director**

5. Social Security Number: 224-34-5386
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 02 09 31
9. Birthplace (State or Foreign Country): VA

Usuel Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1613 Ramblewood Road
10f. Zip Code: 21239
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4th grade; College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Social Security Adm.

17. Father's Name (First, Middle, Last): Charles Spencer
18. Mother's Name (First, Middle, Maiden Surname): Mary Nolan

19a. Informant's Name/Relationship (Type, Print): Patricia Murray-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7508 Shelowood Road, Pikesville, Md 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet
Date: 6/14/02
20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funeral Service Licensee: Glynn B. Keke
22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Physician /Medical Examiner**

23a. Part I Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): e. Lung Cancer — 1 year
Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or es e consequence of):
c. Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of deeth? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Plece of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted.
29b. Signature end title of certifier
29c. License number: D 58303
29d. Date signed (Month, Day, Year): June 8, 2002

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Aaron J. Charles, MD 6601 N. Charles ST Baltimore MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signeture

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Spencer, Lawrence June 8, 2002, 8:00 Am

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2002 18909

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John N. Spruill
2. Date of Death Month: June Day: 06 Year: 2002
3. Time of Death: 0730 Am
4a. Facility Name (If not institution, give street and number): Bon Secour Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 151-34-3362
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 20 1944
9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2207 W. Lexington Street
10f. Zip Code: 21223
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 years
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Fork Lift Operator
16b. Kind of Business/Industry: Westinghouse

17. Father's Name (First, Middle, Last): Kelly Spruill
18. Mother's Name (First, Middle, Maiden Surname): Clara Jones

19a. Informant's Name/Relationship (Type, Print): Sheila V. Spruill/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2207 W. Lexington Street Balto., MD 21223

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Saints Rest Cem.
Date: June 12, 2002
20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service License: Robert F. Emry Jr
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto., MD 21216

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Coronary artery Disease/Ischemia — Approximate Interval Between Onset and Death: 24 hr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Cardiomyopathy/Hypertensive — 10 yrs.
c. Due to (or as a consequence of): Intraventricular Conduction Delay — 15 yrs.
d. Due to (or as a consequence of): Pulmonary Edema — 5 years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Blockage of Circumflex artery

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert Williams MD
29c. License number: D25055
29d. Date signed (Month, Day, Year): 6/6/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT J WILLIAMS 5602 Baltimore National pike Suite 603 Balto 21228

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18910

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROSE A. SNIDER
2. Date of Death: Month June Day 5 Year 2002
3. Time of Death: 6:10 PM
4a. Facility Name (If not institution, give street and number): 21052 VA Medical Center, Fort Howard Md. Fort Howard
4b. City, Town, or Location of Death
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 201-24-0852
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): 9-16-30
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE CO.
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 113 ALCOCK RD.
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1949-'61
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OFFICE SECRETARY
16b. Kind of Business/Industry: GOVERNMENT

17. Father's Name (First, Middle, Last): EDGAR SNIDER
18. Mother's Name (First, Middle, Maiden Surname): GRACE ARBLE

19a. Informant's Name/Relationship (Type, Print): ELIZABETH OTT / SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 206 REPLOGLE SCHOOL RD., NEW ENTERPRISE, PA 16664

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): NEW ENTERPRISE CEM. Date: 06/10/02
20c. Location - City or Town, State: NEW ENTERPRISE, PA

21. Signature of Funeral Service Licensee: DANIEL SIMONS
22. Name and Address of Facility: MARYLAND MORTUARY SUPPORT PO BOX 2938, BALTIMORE, MD 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Ovarian Carcinoma
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: A. Mrowiec
29c. License number: D47804
29d. Date signed (Month, Day, Year): 06/05/2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Andrew Mrowiec, MD 9600 North Point Rd, Fort Howard Md 21052

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: Penelope B Sparks

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Snider, Rose

10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18911

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Irene Frances Schimpf
2. Dete of Deeth — Month, Dey, Year: June 8, 2002
3. Time of Death: 9:05 PM
4e Feclity Neme (If not institution, give street end number): Genesis Eldercare
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Deeth: Baltimore

**Funeral Director**

5. Sociel Security Number: 220-30-7241
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 87 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): April 16, 1915
9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 713 Anneslie Road
10f. Zip Code: 21212
10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12th Grade — College (1-4or 5+): N/A
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Andrew Borcherding
18. Mother's Name (First, Middle, Maiden Surneme): Katherine Wimmert

19a. Informant's Name/Reletionship (Type, Print): Robert Norwood/Son-in-law
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 713 Anneslie Road Baltimore Maryland 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Most Holy Redeemer — Date: 6/12/02
20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Christina L. Hilton — Christina L. Hilton
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214

**To Be Completed by Funeral Director**

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth)
e. End Stage Senile Dementia — Due to (or es e consequence of): — years

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest
b. — Due to (or es e consequence of):
c. — Due to (or es e consequence of):
d.

Part II. **Other signiffcant conditfons** contributing to deeth but not resulting in the underlying cause given in Part I.
Recurrent infections

23b. Did tobecco use contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Meener of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physicfen:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examfner:** On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Martha Raymundo, MD
29c. License number: D54518
29d. Date signed (Month, Dey, Year): 6/10/02

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): MARTHA RAYMUNDO 3007 E Northern Parkway Baltimore MD 21214

**State Registrar**

31. Dete filed (Month, Day, Year): JUN 12 2002
32. Registrer's Signeture: Anna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18912

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Rose Marie Slattery
2. Date of Death: Month June, Day 09, Year 2002
3. Time of Death: 5:00 PM
4a. Facility Name (If not institution, give street and number): Hospice of Baltimore - Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 173-01-9861
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Aug 22, 1919
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Lutherville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1425 Burton Avenue
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Constantine Buono
18. Mother's Name (First, Middle, Maiden Surname): Anna Raimondi

19a. Informant's Name/Relationship (Type, Print): William Daniel Slattery / son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 315 Third Street; Baltimore, MD 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens
Date: 6/12/02
20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Peter O. Clay
22. Name and Address of Facility: RUck Towson FUneral Home, 1050 York Road, Towson, MD 21204

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung CANCER - metastatic — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part tt. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contributa to tha cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of tnjury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and ptace, and due to the cause(s) and manner as stated. 2☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N Anthony Riley MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): June 10, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requiras that the death certificeta be executed within 24 hours efter death.
**To the Funeral Director:** After this certificete has been signed by the attending physician end completely filled in by the funeral director, page 2 should be datached for use es the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

June 9, 2002 @ 5pm.

Rose Slattery

10

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18913

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: DOROTHY MARIE STEWART

2. Date of Death — Month: June Day: 9 Year: 2002

3. Time of Death: 02:28am

4a. Facility Name *(If not institution, give street end number)*: GILCREST NURSING HOME

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 216-20-1410

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Sept 25, 1925

9. Birthplace *(State or Foreign Country)*: MARYLAND

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2503 S PACA STREET

10f. Zip Code: 21230

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12yrs College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BEAUTICIAN

16b. Kind of Business/Industry: COSMETIC

17. Father's Name *(First, Middle, Last)*: DAVID STEWART

18. Mother's Name *(First, Middle, Maiden Surname)*: SADIE CHAMBERS

19a. Informant's Name/Relationship *(Type, Print)*: Anthony Stewart/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5307 Frankford Ave., Baltimore, Md., 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GARRISON FOREST

Date: 06-17-02

20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: Charles D. Powell

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Brain Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: [signature]

29c. License number: D58303

29d. Date signed *(Month, Day, Year)*: June 9 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): AARON J. Charles, MD 6601 N. Charles St. Baltimore, MD 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: JUN 12 2002

32. Registrar's Signature: [signature]

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O./Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

0228

6-9-02

Stewart, Dorothy

30

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18914

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| LEONORA | SALZMAN | JUNE 8,2002 | 10:00 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| MANOR CARE ROLAND PARK | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-10-2942 | 1☐ M 2☒ F | 89 Yrs. | | | OCT.12,1912 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4669 FALLS ROAD | 21210 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| NATHAN | FRIEDMAN | LOTTIE | (UNKNOWN) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ALAN SHAPIRO / FRIEND | 1505 EASTERN AVENUE - BALTIMORE, MD 21231 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | HEBREW FRIENDSHIP CEM | 6/10/2002 | BALTIMORE, MD |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart failure

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Hypothyroidism

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contnbuting to death but not resulting in the underlying cause given in Part I.

Chronic Renal Insufficiency

Depression

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ [signature] MD | D 31464 | 6/10/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHOAIB A. HASHMI 821 N. Eutaw St Suite 308, Balt. MD 21201

**State Registrar**

31. Date filed (Month, Day, Year) JUN 12 2002

32. Registrar's Signature ▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospitel or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funerel Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

02-2986-510
mnmr
Lisa S. Tyler

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 070302: ITEMS#23a,27,28a-f per ME C809 ss

# Certificate of Death

Reg. No. 2002 18915

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Lisa | S. | Tyler | June | 05, | 2002 | 23:40p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital Center | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-84-0078 | 1☐M 2☒F | 32 Yrs. | | | 06 22 69 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3727 Oakmont Ave | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | na | Barber | Barber Shop |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Douglas Whitmore Tyler | Angela Baker |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Angela Baker-Barnett-Mother | 4979 Edgemere Ave, Baltimore Md 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mt. Zion Cemetery | 6/14/02 | Baltimore, Md |

21. Signature of Funeral Service Licensee: Lala March

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. NARCOTIC INTOXICATION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☒Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined | 6-4-02 | Unknown M | 1☐Yes 2☒No | Unknown |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Home | 3727 Oakmont Ave., Baltimore, MD |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | O.C.M.E. | June 06, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Aaron Locke, MD — 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | Barbara G. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18916

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| HARRY ROLAND THORN | June 10, 2002 | 6:13 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2113 Bellvale Rd. | Fallston | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-12-0675 | 1☒M 2☐F | 81 Yrs. | | | May 1, 1921 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Fallston | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2113 Bellvale Rd. | 21047 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 1 | Manager | Automobile Dealership |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Howard John Thorn | Margaret Marie Moore |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Michaele S. Thorn/wife | 2113 Bellvale Rd, Fallston, MD 21047 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gardens of Faith | 6/14/02 | Overlea, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Amyotrophic Lateral Sclerosis — 3years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D20673 | 6-11-02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George Lowe 7672 Belair Rd Rosedale, MD 21236

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Billie Jo Vance
02-3086-510
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar UNPENDED 061802:ITEMS#23a,27,28a-f per ME G808 ss

Reg. No. 2002 18917

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Billie Jo Vance | June | 09 | 2002 | 1:44 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Harbor Hospital Center | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-70-4221 | 1☐ M 2☒ F | 48 Yrs. | | | May 14, 1954 | West Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 411 Maude Avenue | 21225 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Housewife | Home Maker |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Fred Vance | Ruby Harper |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jerry L. Stull/Companion | 411 Maude Avenue, Baltimore, Maryland 21225 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Cherry Hill Cemetery | 06-14-2002 | Upper Track, WV |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| George M Hampton Jr | McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Street, Baltimore, MD 21225 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEIZURE DISORDER | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. REMOTE HEAD INJURIES | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☒ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒ Yes 2☐ No | 1☒ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | 7-6-81 | Unknown M | 1☐ Yes 2☒ No | Passenger of motor vehicle involved in a motor vehicle collision |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| street | Pennington & Church Streets, Balto., MD |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J. M. Ripple for | O.C.M.E. | June 10, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | Bonnie L. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

CPM
02-3049-005
ERIK VARACALLE

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061902: ITEMS#23a,27,28a-f per ME G808 ss

# Certificate of Death

Reg. No. 2002 18918

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Erik Christopher Varacalle | JUNE 7, 2002 | 11:32 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 10300 PULASKI HIGHWAY | WHITE MARSH | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-06-4931 | 1[X] M 2[ ] F | 29 Yrs. | | | Dec. 8, 1972 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1[ ] Yes 2[X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 25 Carriage Walk Court | 21234 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Agronomist | Chemical Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph H. Varacalle, Sr. | Stephanie Marchel |

| 19a. Informant's Name/Relationship (Type, Print) (wife) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Jennifer Rita Varacalle | 25 Carriage Walk Ct., Baltimore, MD 21234 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | Gardens of Faith Cem. | 6/12/02 | Baltimore, Maryland |

21. Signature of Funeral Service Licensee: Christina L. David

22. Name and Address of Facility: Schimunek Funeral Homes, 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. NARCOTIC INTOXICATION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1[ ] Yes 2[ ] No 9[ ] Unknown | 1[ ] Live birth 2[ ] Fetel death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[✓] No 3[ ] Probably 4[ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1[✓] Yes 2[ ] No | 1[ ] Yes 2[ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1[X] Yes 2[ ] No | Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[ ] Residence 6[X] Other (Specify) SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[ ] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[X] Could not be determined | 6-7-02 | Found: 11:00a M | [X] Yes 2[ ] No | Unknown |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Found in restroom | 10300 Pulaski Highway, Balto. County, MD |

29a. Certifier (Check only one)
1[ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[X] **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Marjorie Turnbull MD | O.C.M.E. | JUNE 8, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARJORIE A. TURNBULL 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | Brenda G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examiner or must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18919

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Veronica Ward

2. Date of Death Month Day Year: June 4 2002

3. Time of Death: 3-25 M

4a. Facility Name (If not institution, give street and number): Ben Secours Hospital, Balto

4b. City, Town, or Location of Death: MD

4c. County of Death:

**Funeral Director**

5. Social Security Number: 218-86-0949

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07-10-1962

9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3418 Peidmont AVE

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAIL ROOM

16b. Kind of Business/Industry: CANDY STORE

17. Father's Name (First, Middle, Last): Roy Thomas WARD

18. Mother's Name (First, Middle, Maiden Surname): GLORIA DELORIS HARRIS

19a. Informant's Name/Relationship (Type, Print): MARY WARD GREEN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3418 Peidmont AVE Balto Md 21216

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt CARMEL

Date: 6-8-2002

20c. Location - City or Town, State: BALT MD

21. Signature of Funeral Service Licensee: Phillip A Weatherford

22. Name and Address of Facility: CHRIS FUNERAL HOME 2007 EASTERN AVE BALTO MD 21231

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular disease — 4yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. End stage Renal disease — 4yrs

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

H/O Substance Abuse

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amatan N Maeem MD

29c. License number: D 15503

29d. Date signed (Month, Day, Year): June, 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AMATUL N MAEEM, 501 Dolphin st, Balto, MD 21217

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002

32. Registrar's Signature: Bruce B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospitel or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

2

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2002 18920

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Dorothy Carr Winter

2. Date of Death (Month, Day, Year): June 6 2002

3. Time of Death: 12:00 a.m.

4a Facility Name (If not institution, give street and number): Millennium - South River

4b. City, Town, or Location of Death: Edgewater

4c. County of Death: Anne Arundel

5. Social Security Number: 577-10-8653

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 24,1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2574 Riva Road, #6

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Donald Ford

18. Mother's Name (First, Middle, Maiden Surname): Ruby Mae Kirchner

19a. Informant's Name/Relationship (Type, Print): Benjamin A. Winter, III (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1182 Mt. Airy Road, Davidsonville, MD 21035

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem.

Date: 06/10 2002

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Thomas V. Hardesty

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I. Congestive Heart failure.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ADITYA CHOPRA

29c. License number: D57028

29d. Date signed (Month, Day, Year): 6/7/02

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): 621 Ridgely Ave, Suite 601 Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year): JUN 12 2002

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death* Reg. No. 2002 18921

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): Walter J. Williams Sr.
2. Dete of Deeth Month: June Dey: 08 Year: 2002
3. Time of Death: 9:30pm
4a Fecility Name (If not institution, give street end number): 3839 Southern Cross Drive
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 215-60-0267
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthdey): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): 04 13 52
9. Birthplace (State or Foreign Country): VA

Usuel Residence of Decedent

10a. Stete: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street end Number: 3839 Southern Cross Drive
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 10th grade; College (1-4or 5+): na
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Auto Mechanic
16b. Kind of Business/Industry: Self Employed

17. Father's Neme (First, Middle, Last): Thomas Lee Williams
18. Mother's Name (First, Middle, Maiden Surname): Ella Williams

19a. Informant's Name/Relationship (Type, Print): Mary Roney-Sister
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 3839 Southern Cross Drive, Baltimore Md 21207

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Woodlawn Cemetery
Date: 6/13/02
20c. Location - City or Town, State: Baltimore Co, Md

21. Signature of Funeral Service Licensee: Glynn B Keke
22. Name and Address of Feciliity: March F/H West 4300 Wabash Ave, Baltimore Md 21215

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SQUAMOUS CELL CARCINOMA OF HEAD & NECK — UNKNOWN

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOME HOSPICE

27. Menner of Deeth: 1 X Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner es steted. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Doug D Ross
29c. License number: D0026327
29d. Date signed (Month, Day, Year): 6-10-2002

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): DOUGLAS D. ROSS, 6114 CAMPFIRE, COLUMBIA, MD 21045

**State Registrar**

31. Dete filed (Month, Day, Year): JUN 12 2002
32. Registrer's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18922

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| CATHERINE T. WILSON | JUNE 08, 2002 | 3:00 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HOWARD COUNTY GENERAL HOSP | COLUMBIA, MD. | HOWARD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Dey, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-16-1950 | 1☐M 2☒F | 76 Yrs. | | | Jul 8, 1925 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Ellicott City | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2490 McKenzie Road | 21042 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Howard Tydings | Irene Lucas |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Joanne Lantz-daughter | 2490 McKenzie Road, Ellicott City, MD 21042 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Glen Haven Memorial | Jun 11, 2002 | Glen Burnie, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | Singleton Funeral Home 1 Second Avenue S.W. Glen Burnie, MD 21061 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. GASTROINTESTINAL BLEEDING | 12 HOURS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS TYPE 2

CEREBROVASCULAR DISEASE

DEMENTIA.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| | D42680 | JUNE, 09, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SABA SHEIKH M.D. 9051 BALTIMORE NATIONAL PIKE, SUITE 4C, ELLICOTT CITY MD 21042

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 12 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18923

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DEAN N. WOLFKILL
2. Date of Death (Month, Day, Year): JUNE 4 2002
3. Time of Death: 2:49 A M
4a. Facility Name (If not institution, give street and number): STELLA MARIS@ MERCY HOSPICE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 220-24-7041
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 10, 1928
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3501 ST. PAUL STREET
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1950 1952
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): CHARLES E. WOLFKILL
18. Mother's Name (First, Middle, Maiden Surname): BERTHA M. WOLFKILL

19a. Informant's Name/Relationship (Type, Print): DEBORAH HAMILTON (GUARDIAN)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 N. CALVERT STREET BALTIMORE, MD 21218

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST VET.
Date: 6/12/02
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MARYLAND 21217

**Physician /Medical Examiner**

22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Pancreatic Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia
Chronic Alcohol Abuse

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) STELLA MARIS AT MERCY HOSPICE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D40854
29d. Date signed (Month, Day, Year): JUNE 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 ST PAUL PL, BALTIMORE, MD 21202

**State Registrar**

31. Date filed (Month, Day, Year): JUN 12 2002
32. Registrar's Signature: B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

02-2992-021
Blaine F. Abrecht
lew

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061402:ITEMS#23a,27,28a-f per ME G608 ss **Certificate of Death**

Reg. No. 2002 18924

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BLAINE FRANKLIN ABRECHT

2. Date of Death: Month June; Day 05; Year 2002

3. Time of Death: 13:37 M

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 214-98-6924

6. Sex: 1 X M 2 F

7. Age (In yrs. last birthday): 20 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth (Month, Day, Year): Nov. 29, 1981

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 X Yes 2 No

10e. Street and Number: 432 West South Street

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 X Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber

16b. Kind of Business/Industry: Plumbing

17. Father's Name (First, Middle, Last): Stephen Lawrence

18. Mother's Name (First, Middle, Maiden Surname): Rosemary G. Abrecht

19a. Informant's Name/Relationship (Type, Print): Rosemary G. Abrecht (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 432 West South Street, Frederick, MD 21701

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: 6/10/02

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. COMPLICATIONS OF NARCOTICS AND COCAINE USE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 Naturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 X Could not be determined

28a. Date of Injury (Month, Day Year): Found: 5-31-02

28b. Time of Injury: Unknown M

28c. Injury at Work? 1 Yes 2 X No

28d. Describe how injury occurred: Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 432 W. South St., Frederick, MD

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): June 06, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18925

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Stanley H Arthur
2. Date of Death (Month, Day, Year): May 31 2002
3. Time of Death: 11:30PM
4a. Facility Name (If not institution, give street and number): Covien Nursing Home
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard
5. Social Security Number: 031-01-9100
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jul. 5, 1917
9. Birthplace (State or Foreign Country): Massachussetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 3557 Plum Tree Drive
10f. Zip Code: 21042
10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Driver
16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): James Daniel Arthur
18. Mother's Name (First, Middle, Maiden Surname): Margaret May Smith

19a. Informant's Name/Relationship (Type, Print): Virginia Russell/Daughter
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 9106 Dunloggin Road Ellicott City, MD 21042

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mass. National Cemetery
Date: 6/13/02
20c. Location - City or Town, State: Bourne, MA

21. Signature of Funeral Service Licensee: Karen Collins-Wyle M01044
22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. congestive heart failure — 3 years

Due to (or es a consequence of):
b. coronary artery disease — 10 years

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
dementia
malnutrition

23b. Did **tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end Title of certifier: Kaplan MD
29c. License number: D41617
29d. Date signed (Month, Day, Year): June 1, 2002

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Gary Kaplan MD 10805 Hickory Ridge Rd Columbia MD 21044

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JUN 04 2002
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18926

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| CHARLES | EDWARD | BOWMAN | May 29 2002 | 15:15 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | None |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214 38 5325 | 1☒ M 2☐ F | 61 Yrs. | | | July 28, 1940 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Howard | Ellicott City | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4644 Woodland Road | 21042 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | Iron Worker | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Edward Bowman | Mary Anna Barth |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Charles Lee Bowman/Son | 4644 Woodland Road Ellicott City, MD 21042 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Crest Lawn Cemetery | 6-1-2002 | Marriottsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Sherri Collins-Wylie MO1044 | Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 |

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE STROKE | FOUR DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Jeffrey A. Rumbaugh, MD | RES-000 | MAY 29, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JEFFREY A. RUMBAUGH, MD 600 NORTH WILFE STREET BALTIMORE, MARYLAND 21287

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 31 2002 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18927

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Gerald Bounds

2. Date of Death (Month, Day, Year): May 25, 2002

3. Time of Death: 4:26 AM

4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 216-38-3655

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 28, 1942

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 815 Lorine Court

10f. Zip Code: 21001

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self employed

16b. Kind of Business/Industry: Appliance

17. Father's Name (First, Middle, Lest): Floyd S. Bounds, Jr.

18. Mother's Name (First, Middle, Maiden Surname): Helen Aro

19a. Informant's Name/Relationship (Type, Print): Nancy Bounds (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 815 Lorine Court, Aberdeen, Maryland 21001

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Grove Presbyterian Cemetery | Date: 5/28/02

20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: Kristen Ann Ungles bee

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. hypertension — Due to (or as a consequence of): — 10 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Silverstein MD

29c. License number: D27154

29d. Date signed (Month, Day, Year): 5/25/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Louis Silverstein 805 S. Union Ave Hdg MD 21078

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002

32. Registrar's Signature: Geneva G Sparks

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18928

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| William J. Benson, Jr. | May 24, 2002 | 12:10 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Stella Maris Hospice | Timonium | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-16-1993 | 1 [X] M 2 [ ] F | 82 Yrs. | | | Feb. 2, 1920 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3508 Northway Drive | 21234 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th Grade | | Firefighter - Lieut. | Baltimore City |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William J. Benson, Sr. | Margaret Wiessner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Anna Benson (wife) | 3508 Northway Drive, Baltimore, MD 21234 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Gardens of Faith Cem. | 5/29/02 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multi-system organ failure secondary to thoraco-

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. abdominal aneurysm repair

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D43725 | May 24, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood 2300 Dulaney Valley Road Timonium, MD 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | [signature] G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

MAY 24, 2002 12:10 AM

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

WILLIAM BENSON

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18929

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: GLORIA DALE CHRISTOPHER

2. Dete of Deeth: Month MAY Dey 26 Year 2002

3. Time of Death: 12:20 AM

4a. Fecility Neme *(If not institution, give street and number)*: MARINER HEALTH OF FOREST HILL

4b. City, Town, or Location of Death: FOREST HILL

4c. County of Deeth: HARFORD

**Funeral Director**

5. Social Security Number: 219-16-7877

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: May 7, 1925

9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street end Number: 103 Fairmont Drive

10f. Zip Code: 21014

10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: William Binford Stonnell

18. Mother's Name *(First, Middle, Maiden Surneme)*: Olivia Dorothea Knudson

19a. Informant's Name/Relationship *(Type, Print)*: Robert Christopher - Husband

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 103 Fairmont Drive, Bel Air, Maryland 21014

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp.

Date: 5/29/02

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Stephen A. Dench

22. Name end Address of Fecility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)
e. presumed aspiration pneumonia — < 3 days

Due to (or es e consequenca of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: David S. Dunn

29c. License number: D32255

29d. Date signed *(Month, Dey, Year)*: May 2C, 2002

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dav. D S. Dunn 6.5 W. Macha. / Rolair MD 21014

**State Registrar**

31. Dete filed *(Month, Day, Year)*: MAY 29 2002

32. Registrer's Signature: Jeanine G Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18930

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Evelyn Elizabeth Clements
2. Date of Death (Month, Day, Year): May 25 2002
3. Time of Death: 6:00 A M
4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center
4b. City, Town, or Location of Death: Bel Air,
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 578-38-0176
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 6, 1930
9. Birthplace (State or Foreign Country): District of Columbia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2942 Salford Drive
10f. Zip Code: 21009
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 3
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edward (nmn) Curtin
18. Mother's Name (First, Middle, Maiden Surname): Edna (u/k) Darnell

19a. Informant's Name/Relationship (Type, Print): Frank H. Clements, Jr.- Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2942 Salford Drive, Abingdon, Maryland 21009

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.
Date: 5-28-02
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Charles A. Engel Jr.
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Congestive Heart Failure
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: William P. Cook MD
29c. License number: D47596
29d. Date signed (Month, Day, Year): May 25, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Cook, MD 1131 Bel Air Road, Bel Air, MD 21014

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 | 8931

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jen-Hua Chang

2. Date of Death (Month, Day, Year): May 28, 2002

3. Time of Death: 6:30 AM

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Nursing Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 434-21-1044

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 3, 1910

9. Birthplace (State or Foreign Country): China

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9901 Sunset Drive

10f. Zip Code: 20850

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Educetion (Specify only highest grede completed): Elementery/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): "Unknown" Wang

18. Mother's Name (First, Middle, Maiden Surname): "Unknown" Chu-Gu

19a. Informant's Name/Relationship (Type, Print): Wayne H. Chang (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9901 Sunset Drive - Rockville, Maryland 20850

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 5/28/02

20c. Location - City or Town, State: Alexandria, VA.

21. Signature of Funeral Service Licensee: Robert A. DeVol

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive-Gaithersburg, MD. 20877

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. cardiopulmonary arrest | one day |
| Due to (or es e consequence of): | | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last | b. anorexia | 6 months |
| Due to (or es e consequence of): | | |
| | c. old age | |
| Due to (or as e consequence of): | | |
| | d. | |

Part II. **Other significent conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: H. Victor Chiang MD PhD

29c. License number: D 34969

29d. Date signed (Month, Day, Year): May 28, 2002

30. Neme end address of person who completed cause of death (item 23e) (Type, Print): H. Victor Chiang, MD. PhD. 9707 Medical Center Dr. Suite 320. Rockville, MD 20850

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrer's Signature: Samuel G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Mor 23A

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18932

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: ELIZABETH EDWARDS

2. Dete of Death Month / Day / Yeer: JUN 03 2002

3. Tima of Death: 11:00P.M.

4e Facility Neme *(If not institution, give street end number)*: HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Deeth: HOWARD

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age *(In yrs. lest birthdey)* | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Dete of Birth *(Month, Day, Year)* | 9. Birthplace *(Stete or Foreign Country)* |
|---|---|---|---|---|---|---|
| 214-36-9210 | 1☐ M 2☒ F | 64 Yrs. | | | Oct 11, 1937 | West Virginia |

Usuel Residence ol Decedent

| 10a. Stete | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| WV | Berkeley | Martinsburg | 1☒ Yes 2☐ No |

10e. Street end Number: 305 South Kentucky Avenue

10f. Zip Code: 25401

10g. Citizen ol Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Conference of United Methodist Church

17. Father's Name *(First, Middle, Last)*: Homer Garland Spitzer

18. Mother's Name *(First, Middle, Maiden Surname)*: Thelma Angeline Dick

19a. Informant's Name/Relationship *(Type, Print)*: James G. Spitzer /brother

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 3338 Sudlersville South, Laurel, Maryland 20724

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Emmanuel Cemetery

Date: 6/10/02

20c. Location - City or Town, Stata: Scaggsville, Maryland

21. Signature of Funeral Service Licensee: M00773

22. Nama end Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

**To Be Completed by Funeral Director**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode ol dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
e. Respiratory failure — months

Due to (or es e consequence of):
b. Pulmonary hypertension — months

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted evants resulting in death) Last
c. Chronic hypoxemia — months

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

Obstructive sleep apnea, hypertension, Beesty, drabetes mellitus, renal insufficiency, pneumonia

23b. Did tobacco use contribute to tha causa of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy lindings aveilable prior to completion ol cause of deeth? 1☐ Yas 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner ol Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date ol Injury *(Month, Dey Year)*

28b. Time ol Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place ol Injury - At home, larm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end menner stated.

29b. Signature and title of certifier: MD, FCCP

29c. License number: D36845

29d. Date signed *(Month, Day, Yeer)*: Jun. 03, 2002

30. Name end eddress ol person who completed cause ol deeth (Item 23e) (Type, Print): MAI-CHI NGUYEN, MD, FCCP 7350 Grace Drive, Columbia, MD 21044

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after deeth.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

**State Registrar**

31. Dete filed *(Month, Day, Year)*: JUN 05 2002

32. Registrar's Signeture: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18933

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| John William Joseph Faber | May 31, 2002 | 11:20p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 505 Prince Charles Avenue | Odenton | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-38-8154 | 1☐M 2☐F X | 72 Yrs. | | | Oct 14, 1929 | Maryland |

Usuet Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Odenton | 1☐Yes 2☐No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 505 Prince Charles Avenue | 21113 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1946 – 1967 | 1☐Yes 2☒No XX Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| Grade 12 | | Systems Analyst | Dept. of Defense |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harry Faber | Anna Marie Ruppert |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ingeburg E. Faber / spouse | 505 Prince Charles Avenue Odenton, Maryland 21113 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metropolitan Crem, Inc | 6/3/02 | Alexandria, Virginia |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] / M00770 | Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. congestive heart failure | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. esophageal cancer | |
| | Due to (or as a consequence of): | |
| | c. Parkinsonism. | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown XX

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No XX | 1☐Yes 2☒No XX |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No XX | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence XX 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural XX 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ JoAnn Rosenfeld MD | D25683 MD | 6/3/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JoAnn Rosenfeld, MD Route 175, Odenton, Maryland

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 05 2002 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(14)

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18934

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jean Padula Froehlich
2. Date of Death (Month, Day, Year): May 18, 2002
3. Time of Death: 9:00 AM
4e. Facility Name (If not institution, give street and number): 1201 Georgetown Drive
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 193-32-2559
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 18, 1938
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1201 Georgetown Drive
10f. Zip Code: 21014
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lab Technician
16b. Kind of Business/Industry: John Hopkins University School Of Hygiene

17. Father's Name (First, Middle, Last): George Washington Padula
18. Mother's Name (First, Middle, Maiden Surname): Hazel Lorraine Dosch

19a. Informant's Name/Relationship (Type, Print): Harry Froehlich / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1201 Georgetown Dr., Bel Air, MD 21014

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hillton Service Corp.
Date: 5-22-02
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Stanley A. Murphy
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: JI Fong MD
29c. License number: MD 18320
29d. Date signed (Month, Day, Year): 5/21/02

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John Fong MD 10753 Falls Rd. Lutherville MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

02-2730-025
mnmr
Shirley Fanz

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061302: ITEMS#23a,27 per ME 6808 ss

# Certificate of Death

Reg. No. 2002 18935

**Physician /Medical Examiner** | **Funeral Director**

1. Decedent's Name (First, Middle, Last): Shirley Jane Fanz
2. Date of Death: Month May Day 26, Year 2002
3. Time of Death: 10:50 AM
4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford
5. Social Security Number: 192-22-2188
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 18, 1932
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 122 Valley Road
10f. Zip Code: 21001
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 12; College (1-4or 5+) 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Employment Coorinator
16b. Kind of Business/Industry: Placement
17. Father's Name (First, Middle, Last): Christian Spencer Fanz
18. Mother's Name (First, Middle, Maiden Surname): Jane Moss
19a. Informant's Name/Relationship (Type, Print): George Breder
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 215 Decoy Dr., Havre de Grace, MD 21078
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington Cemetery
Date: 5/30/02
20c. Location - City or Town, State: Drexel Hill, PA
21. Signature of Funeral Service Licensee: Frank S. Zell II
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? ☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? ☒ Yes 2☐ No
25. Was case referred to medical examiner? ☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): May 27, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA KUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

Amend Item 19b per F.D. 05/29/2002, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18936

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): George Kenneth Flinkman
2. Date of Death — Month: MAY; Dey: 27; Year: 2002
3. Time of Death: 1315 PM
4e. Facility Name (If not institution, give street end number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

**Funeral Director**

5. Social Security Number: 213-26-7181
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthdey): 72 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Dec. 16, 1929
9. Birthplace (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: PA
10b. County: Adams
10c. City, Town or Location: Littlestown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 17 Trenton Court
10f. Zip Code: 17340
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Milk Deliveryman
16b. Kind of Business/Industry: Dairy
17. Father's Name (First, Middle, Last): Ellis Flinkman
18. Mother's Name (First, Middle, Maiden Surname): Melville Coons
19a. Informant's Name/Relationship (Type, Print): Mrs. Linda L. Flinkman (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 Trenton Court, Littlestown, PA 17340 ~~17 Trenton Court, Littlestown, PD 17340~~
20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Old Oakland Cemetery
Date: 5/30/02
20c. Location - City or Town, State: Sykesville, MD
21. Signature of Funeral Service Licensee: Brian K. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

FLINKMAN, GEORGE

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760, Carroll 934**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. MITRAL VALVE REGURGITATION — 10 YEARS

Due to (or as a consequence of): b. RHEUMATIC FEVER — 50 YEARS

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

Due to (or as e consequence of): c.

Due to (or as e consequence of): d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.: CORONARY ARTERY DISEASE

23b. **Did tobacco uee contribute to the cause of death?** 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes cese referred to medical examiner? 1☑Yes 2☐No

26. Place of Deeth (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Peter W. Cito MD
29c. License number: D41129
29d. Date signed (Month, Dey, Yeer): MAY 27, 2002

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): PETER W. CITO MD SINAI HOSPITAL OF BALTIMORE, 2401 W. BELVEDERE AVE, BALT., MD 21215

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 8

**State Registrar**

31. Dete filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18937

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Benjamin Grau

2. Date of Death: Month MAY Day 19 Year 2002

3. Time of Death: 00:20 M

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-28-5045

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 27, 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1718 Montpelier St.

10f. Zip Code: 21218

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Produce Manager

16b. Kind of Business/Industry: Grocery

17. Father's Name (First, Middle, Last): William Grau

18. Mother's Name (First, Middle, Maiden Surname): Stella Wilkinson

19a. Informant's Name/Relationship (Type, Print): Mary Grau (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1718 Montpelier St., Baltimore, Maryland 21218

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Date: 5/22/2002

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian A. Wallace

22. Name and Address of Facility: Schimunek Funeral Homes, 3331 Brehms Lane, Baltimore, Maryland 21213

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia — Approximate Interval Between Onset and Death: 5 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Electrolyte Imbalance — 4 days

Due to (or as a consequence of):

c. Bowel Obstruction — 4 days

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Coronary artery disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [✓] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: AT 243894

29d. Date signed (Month, Day, Year): MAY 19 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HARVEY MATED UNION MEMORIAL HOSPITAL MD 21218

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

PATRICIA GARRISON
rkd

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061302:ITEMS#23a,27 per ME 6808 ss

# Certificate of Death

Reg. No. 2002 18938

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Patricia Lorraine Garrison
2. Date of Death: Month MAY Day 29 Year 2002
3. Time of Death: 4:07A. M
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 578-58-8286
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 26,1945
9. Birthplace (State or Foreign Country): Washington, D.C.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Poolesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15205 Montevideo Road
10f. Zip Code: 20837
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4or 5+):
16a. Decedent's Usual Occupation (Specify kind of work done during most of working life. DO NOT use retired): Caretaker
16b. Kind of Business/Industry: Elder Care

17. Father's Name (First, Middle, Last): Lawrence Ferrell
18. Mother's Name (First, Middle, Maiden Surname): Doris Sullivan

19a. Informant's Name/Relationship (Type, Print): Robert W. Garrison / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15205 Montevideo Rd. Poolesville, MD 20837

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Crematory
Date: May 31,2002
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☒ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): MAY 30,2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

2

**State Registrar**

31. Date filed (Month, Day, Year): JUN 03 2002
32. Registrar's Signature:

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18939

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Marie Frances Hammond

2. Date of Death: Month MAY Day 21 Year 2002

3. Time of Death: 5 50 PM

4e. Facility Name (If not institution, give street and number): MARINER HEALTH - Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: HARFORD

**Funeral Director**

5. Social Security Number: 216-32-0612

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 27, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Belcamp

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4760 D Water Park Drive

10f. Zip Code: 21017

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Catholic Church

17. Father's Name (First, Middle, Last): Joseph (u/k) Waechter

18. Mother's Name (First, Middle, Maiden Surname): Josephine (u/k) Mertz

19a. Informant's Name/Relationship (Type, Print): Phyllis E. Kashella / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4760 D Water Park Dr., Belcamp, Maryland 21017

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart Of Jesus Cem.

Date: 5-24-02

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Stanley A Keefe

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cerebro Vascular Accident — 1 WK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CAD CHF Cardiac arrhythmia

Renal failure

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William MD

29c. License number: D32609

29d. Date signed (Month, Day, Year): 5/22/02

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): KAMRUDIN MITHANI MD 1106 Revolution St. Havre De Grace MD 21078

**State Registrar**

31. Date filed (Month, Day, Year): MAY 24 2002

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HAMMOND, MARIE

8

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18940

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ruth Minnettee Johnson

2. Date of Death: Month MAY Day 24 Year 2002

3. Time of Death: 1:30 PM

4a. Facility Name (If not institution, give street and number): Citizens Nursing Home

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 163-20-6087

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 23, 1925

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 147 West Deen Ave.

10f. Zip Code: 21001

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dept. Manager

16b. Kind of Business/Industry: Retail Sales

17. Father's Name (First, Middle, Last): Roy Kenneth Crouthamel

18. Mother's Name (First, Middle, Maiden Surname): Ruth Cope Shelly

19a. Informant's Name/Relationship (Type, Print): Mathes L. Johnson (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 147 West Deen Ave., Aberdeen, Maryland 21001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harford Memorial Gardens

Date: 5/28/02

20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: Ilana Christina Capitano

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive lung disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid arthritis
Diabetes
hypertension

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hans Jan Gut

29c. License number: D37364

29d. Date signed (Month, Day, Year): May 24, 2002.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 19 Walnut Lane, Aberdeen, Maryland

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

LM

Johnson, Ruth M.

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18941

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Susie A. Jones | May 27 2002 | 6:45 aM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1029 Old Pylesville Road | Pylesville | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-28-5908 | 1☐M 2☒F | 89 Yrs. | | | 7/4/1912 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Pylesville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1029 Old Pylesville Road | 21132 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| Unknown | | Homemaker | Own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Cleveland Boyle | Inez Orr |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Donald W. Jones - Son | 2602 Exeter Road, Wilmington, DE 19810 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Slate Ridge Cem. | 5/30/02 | Delta, PA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Jeffrey P. Lovelidge | Harkins Funeral Home, Inc., Delta, PA |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CONGESTIVE HEART FAILURE | YEARS |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. ISCHEMIC CARDIOMYOPATHY | |
| | Due to (or as a consequence of): | |
| | c. CORONARY ARTERY DISEASE | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ VMAbhyankar MD | D25027 | 5/28/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VIJAY M. ABHYANKAR 2 NORTH AVE. BEL AIR MD 21014

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 29 2002 | ▶ Geneva G Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attanding Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LM

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18942

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Julia Rose Kanyuch
2. Dete of Death: Month May Day 28, Year 2002
3. Time of Death: 2.55PM
4e. Fecility Neme (If not institution, give street and number): 118 Carol Avenue
4b. City, Town, or Location of Deeth: Aberdeen
4c. County of Deeth: Harford

**Funeral Director**

5. Social Security Number: 234-86-8112
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 2, 1918
9. Birthplace (State or Foreign Country): Ohio

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 118 Carol Avenue
10f. Zip Code: 21001
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: In home

17. Father's Neme (First, Middle, Last): Stanley Ziemba
18. Mother's Name (First, Middle, Maiden Surname): Anna Swiatek

19a. Informant's Name/Reletionship (Type, Print): David J. Kanyuch (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6743 Crossbrock Dr., Centerville, Ohio 45459

20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Union Cemetery
Date: 6/1/02
20c. Location - City or Town, State: St. Clairsville, OH

21. Signeture of Funeral Service Licensee: Kirsten A. Unglesbee
22. Name and Address of Fecility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pancreatic Tumor — ~3 month

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest:
b.
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availabte prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes cese referred to medicat examiner? 1☐ Yes 2☒ No

26. Ptace of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Claudia A. Kroker MD, FACP
29c. License number: D50040
29d. Date signed (Month, Day, Year): May 28th 2002

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): 1308 Business Center Way, Suite 102, Edgewood, MD 21040

**State Registrar**

31. Dete filed (Month, Day, Year): MAY 30 2002
32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2002 18943
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ALFRED EDWARD LANNING, Jr. | May 27, 2002 | 10:00 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Laurel Regional Hospital | Laurel | Prince George |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-72-0713 | 1☒M 2☐F | 43 Yrs. | | | Sept 28, 1958 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Howard | Jessup | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8303 Ashwood Road | 20794 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Backhoe/heavy equipment oper. | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Alfred Edward Lanning, Sr. | Shirley Henson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Alfred E. Lanning, Sr. /father | 3354 Cranberry South, Laurel, Maryland 20724 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) entombment | Meadowridge Mem Pk. | 5/31/ 2002 | Dorsey, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] M00770 | Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Respiratory failure | 4 weeks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Metastatic esaphageal cancer | 9 months |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Martin O. Weltz MD | D23743 | May 28, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Martin Weltz 7525 Greenway Center Drive, Greenbelt, Maryland 20770

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 31 2002 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18944

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HERMIT OLLIE LIGHT

2. Dete of Deeth: Month MAY; Day 26; Year 2002

3. Time of Death: 6:50 AM

4e Fecility Neme (If not institution, give street end number): MARINER HEALTH OF FOREST HILL

4b. City, Town, or Location of Deeth: FOREST HILL

4c. County of Death: HARFORD

**Funeral Director**

5. Social Security Number: 215-30-5984

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth (Month, Dey, Year): July 22, 1915

9. Birthplece (State or Foreign Country): W. Virginia

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: ☒Yes 2☐No

10e. Street end Number: 115 South Kelly Avenue

10f. Zip Code: 21014

10g. Citizen of What Counfry?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): John Henry West

18. Mother's Name (First, Middle, Maiden Surneme): Lucy Margaret Rodes

19a. Informant's Neme/Reletionship (Type, Print): Lucy Slaich - Daughter

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 821 W. Jarrettsville Rd., Forest Hill, MD 21050

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Grdns.

Date: 5/29/02

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Stephen A Meeks

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: David S. Dunn

29c. License number: D32295

29d. Date signed (Month, Day, Yeer): May 28, 2002

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): DAVID S. DUNN 615 W. MacPhail Belair MD 21014

**State Registrar**

31. Dete filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requiras that the daath certificate ba executed within 24 hours efter deeth.

**To the Funeral Director:** Aftar this certificate has been signed by the attending physician and completely filled in by the funeral director, pega 2 should be datached for use es the buriel-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18945

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| William Law, Jr. | MAY 25, 2002 | 9:15 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Union Memorial Hospital | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-36-0611 | 1 X M 2 ☐ F | 62 Yrs. | | | Oct. 31, 1939 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3600 Kenyon Avenue | 21213 | U. S. A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates 1957-1960 | 1 ☐ Yes 2 X No Specify: | Specify: |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Administrator | Maryland State Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Law, Sr. | Mary Virginia Henderson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sharon L. Law (Wife) | 3600 Kenyon Avenue, Baltimore, Maryland 21213 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory, or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) Entombment | Gardens of Faith Mausoleum | 5/30/2002 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Carl Blumberg | Schimunek Funeral Homes 3331 Brehms Lane, Baltimore, Maryland 21213 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ARRhythmiA | 2HRS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): ischemic CArdiomyopAthy | 34yRS. |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

LH

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 ☐ Yes 2 X No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown | 1 ☐ Yes 2 X No | 1 ☐ Yes 2 X No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Onaje Greene | AT243 8976 | MAY 25, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Onaje Greene, Union Memorial Hospital, Baltimore, MD.

15

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 30 2002 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18946

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Elizabeth Mills | MAY 30 2002 | 8:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Howard County General Hospital | Columbia | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-34-7972 | 1 ☐ M XX F | 89 Yrs. | | | March 17 1913 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Howard | Laurel | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10690 Old Bond Mill Road | 20723 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 5 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Elias Jenkins | Edith O'Henry |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Betty Coon/Daughter | 10690 Old Bond Mill Road, Laurel, MD 20723 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Emmanuel UMC Cemetery | June 3 2002 | Scaggsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] M00770 | Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEVERE ASPIRATION PNEUMONIA | About 3 weeks |
| Due to (or as a consequence of): | b. OROPHARYNGEAL DYSPHAGIA. | UNKNOWN |
| Due to (or as a consequence of): | c. | |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 ☑ No | Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D0053987 | MAY 30 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENNETH GEE, MD: 300 ARMORY PL, SUITE 1A, Baltimore MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 31 2002 | [signature] G Sparks |

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10)

CGB

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 | 8947

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Agnes McDonald Murdoch

2. Date of Death Month / Day / Year: May 21 2002

3. Time of Death: 4:30 pm

4e. Facility Name *(If not institution, give street and number)*: MARINER HEALTH-BEL AIR

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: HARFORD

**Funeral Director**

5. Social Security Number: 190-24-7628

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 104 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 17, 1898

9. Birthplace *(State or Foreign Country)*: Scotland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 621 Foxcroft Drive

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dietician

16b. Kind of Business/Industry: University

17. Father's Name *(First, Middle, Last)*: Robert Campbell McMurtrie

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Mary Drennan

19a. Informant's Name/Relationship *(Type, Print)*: Margaret Bridson / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 621 Foxcroft Drive, Bel Air, Maryland 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gardens

Date: 5-24-02

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Stanley A. Keech

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway St., Bel Air, Maryland 21014

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration Pneumonia — 24 hours
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Manuel M. MD

29c. License number: D19583

29d. Date signed *(Month, Day, Year)*: May 21, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANUEL M. LAZATIN MD 8 Law Street Aberdeen, Maryland 21001

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 24 2002

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Agnes M. Murdoch

LM

10

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18948

**Physician /Medical Examiner**

**Funeral Director**

1. Decedent's Name (First, Middle, Last): GRACE C. MUFFOLETTO
2. Date of Death: Month May Day 27, Year 2002
3. Time of Death: 7:45 AM
4e. Facility Name (If not institution, give street and number): Gilchrist Center for Hospice Care
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore
5. Social Security Number: 213-32-5942
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/15/1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County: Harford
10c. City, Town or Location: White Hall
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 2533A Bradenbaugh Road
10f. Zip Code: 21161
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Lee Clarence Chambers
18. Mother's Name (First, Middle, Maiden Surname): Marie Norris

19a. Informant's Name/Relationship (Type, Print): Lee Chambers /Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3033 Woodring Ave. Baltimore, Md. 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation — Date: 5/28/02
20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funeral Service Licensee: M. Gladden Kurtz III
22. Name and Address of Facility: E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland 21084

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. BREAST CANCER | 3 YEARS |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as e consequence of): | |
| | c. | |
| | Due to (or as e consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Sydney Byers PHYSICIAN
29c. License number: D53590
29d. Date signed (Month, Day, Year): MAY 27, 2002

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): SYDNEY BY, MD — ROOM 8033 — 1830 EAST MONUMENT BALTIMORE MD 21205

**State Registrar**

31. Dete filed (Month, Day, Year): MAY 29 2002
32. Registrer's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

permit. Pegas 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. **Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requiras that tha death certificete be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician end completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit

15

May 27, 2002 7:45 AM

Muffoletto, Grace

Kipp Alan McCleary
02-2685-005
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18949

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Kipp Alan McCleary
2. Date of Death: Month: May; Day: 24; Year: 2002
3. Time of Death: 1:30 A M

4a. Facility Name (If not institution, give street and number): Harris Mill Road
4b. City, Town, or Location of Death: Parkton
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 201-62-1559
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 31 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 8, 1970
9. Birthplace (State or Foreign Country): Pennsylvania

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: PA
10b. County: York
10c. City, Town or Location: Stewartstown
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3947 Orchard Road
10f. Zip Code: 17363
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator
16b. Kind of Business/Industry: Graphic Design

17. Father's Name (First, Middle, Last): Glenn Alan McCleary
18. Mother's Name (First, Middle, Maiden Surname): Betty Jean Bennington

19a. Informant's Name/Relationship (Type, Print): Kathy M. Gable/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3947 Orchard Road, Stewartstown, PA 17363

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Prospect United Methodist Cem.
Date: May 28, 2002
20c. Location - City or Town, State: New Park, Pennsylvania

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: J.J. Hartenstein Mortuary, Inc 19 S. Main St., P.O. Box 325, Stewartstown PA 17363

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): 5/24/02
28b. Time of Injury: 0100 M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: DRIVER OF CAR WHICH LOST CONTROL AND OVERTURNED
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): ROADWAY
28f. Location (Street and Number or Rural Route Number, City or Town, State): HARRIS MILL ROAD PARKTON, MD

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): May 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY C. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#5 Per FH 5/30/2002 HCHD LM

# Certificate of Death

Reg. No. 2002 18950

**Physician /Medical Examiner**

| 1. Decedent's Neme (First, Middle, Last) | 2. Date of Death Month | Day | Yaar | 3. Time of Deeth |
|---|---|---|---|---|
| EMMA MARIE MOTTL | MAY | 23 | 2002 | 6:30 AM |

| 4a Fecility Neme (If not institution, give street end number) | 4b. City, Town, or Locetion of Deeth | 4c. County of Deeth |
|---|---|---|
| MARINER HEALTH OF FOREST HILL | FOREST HILL | HARFORD |

**Funeral Director**

| 5. Social Sacurity Number | 6. Sax | 7. Age (In yrs. last birthday) | If Under 1 Yaar: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Yeer) | 9. Birthplece (Stete or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| ~~212-07-7024~~ 212-09-7024 | 1☐ M 2☒ F | 84 Yrs. | | | | | Nov. 10, 1917 | Maryland |

Usuel Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Kingsville | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11813 Cedar Lane | 21087 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forcas? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, atc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Yaar or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Eduestion (Specify only highest grada completed) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| Unknown | | Wire Maker | Manufacturing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Mottl | Mary Havl |

| 19a. Informant's Name/Relationship (Typa, Print) | 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| Ms. Mary P. Cumberland (niece) | 11813 Cedar Lane, Kingsville, MD 21087 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Parkwood Cemetery | 5/25/02 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 |

**Physician /Medical Examiner**

LH

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)
a. probable cerebral vascular accident

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's

hypertension

carotid stenosis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Steta)

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.
2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner steted.

| 29b. Signature end title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Yeer) |
|---|---|---|
| ▶ David S. Dunn | D32295 | May 24, 2002 |

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
David S. Dunn 615 W. Macphail Belair MD 21014

**State Registrar**

| 31. Dete filed (Month, Day, Yeer) | 32. Registrer's Signeture |
|---|---|
| MAY 28 2002 | ▶ Geneva G Sparks |

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene.
**Important: If item 27 is marked other than "naturel', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

3

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18951

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BETTY NORMAN
2. Date of Death (Month, Day, Year): JUNE 2nd 2002
3. Time of Death: 1:00A M
4a. Facility Name (If not institution, give street and number): Lorien Nursing Home
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 578-01-7413
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Nov. 8, 1919
9. Birthplace (State or Foreign Country): Washington D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 12290 Green Meadow Drive Apt. 206
10f. Zip Code: 21044
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edward S. Poston
18. Mother's Name (First, Middle, Maiden Surname): Mildred Irene Cross

19a. Informant's Name/Relationship (Type, Print): Beverly A. Wright/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6824 Pyramid Way Columbia, Md. 21044

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 06/04/2002
20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: [signature] M01142
22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SUB ARACHNOID HEMORRHAGE — WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): COPD — MONTHS
c. Due to (or as a consequence of): ATHEROSCLEROSIS — YEARS
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D0053150
29d. Date signed (Month, Day, Year): JUNE 3rd 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHAKUNTALA GUPTA 201-109 BACK RIVER NECK RD BALTIMORE 21221

**State Registrar**

31. Date filed (Month, Day, Year): JUN 04 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18952

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Bessie C. Orlando
2. Date of Death (Month, Day, Year): May 24, 2002
3. Time of Death: 7:25 A M
4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Campus
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 212-01-4475
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 28, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4775 Elison Avenue
10f. Zip Code: 21206
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Textiles

17. Father's Name (First, Middle, Last): Joseph DeFlavis
18. Mother's Name (First, Middle, Maiden Surname): Anna Torregrosso

19a. Informant's Name/Relationship (Type, Print): Mr. Larry Dernetz, Jr. (nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 725 Hollywood Place, Forest Hill, MD 21050

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer
Date: 5/28/02
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Amanda Davis
22. Name and Address of Facility: Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. sepsis syndrome
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. peripheral vascular disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
diabetes
dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: David S. Dunn
29c. License number: D32294
29d. Date signed (Month, Day, Year): May 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID S. DUNN 115 W. MACPHAIL Bel Air MD

**State Registrar**

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: Geneva G Sparks

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18953

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Josephine Marie Onorato
2. Date of Death: Month: May Day: 24 Year: 2002
3. Time of Death: 1950
4a. Facility Name (If not institution, give street and number): The Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 218-52-2075
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01/17/1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3537 Elmley Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Angelo Brocato
18. Mother's Name (First, Middle, Maiden Surname): Felicia Giardina

19a. Informant's Name/Relationship (Type, Print): Mr. Frank J. Onorato / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8408 Avery Road Baltimore, Maryland 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lorraine Park Cemetery
Date: 05/28/02
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Brian A. Miller
22. Name apd Address of Facility: Schimunek Funeral Home, Inc. 3331 Brehms Lane Baltimore, Maryland 21213

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | one month |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or es e consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mark Levis MD
29c. License number: D0052391
29d. Date signed (Month, Dey, Yeer): May 24, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mark Levis, Department of Medicine, Union Memorial Hospital, Baltimore, Maryland 21218

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: ▶ Geneva G' Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after daeth.
**To the Funeral Director:** After this certificate has been signed by the attanding physician and completely filled in by the funerel director, page 2 should be datached for use es the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18954

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Elizabeth Svedonik | JUNE 02 2002 | 12:00 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Agnes Health Care | Baltimore | n/a |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-10-7038 | 1☐M 2☒F | 87 Yrs. | | | Jul. 11, 1914 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Catonsville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 713 Maiden Choice Lane | 21228 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Transportation | U.S. Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Potts | Elizabeth Wiebretch |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Tom Payne/Nephew | 3323 Hibiscus Court Ellicott City, MD 21043 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Crest Lawn Mem. Gard. | 06/06/2002 | Marriottsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Cindy Amato M00845 | Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. STAPHLOCOCCUS BACTEREMIA | DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. PNEUMONIA | DAYS |
| | Due to (or as a consequence of): c. DECUBITUS ULCER | WEEKS |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] M.D | 15626 | JUNE 02, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. TUN NYUNT, ST. AGNES HEALTH CARE, 900 CATON AVE. BALTIMORE, 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 04 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Svedonik, Elizabeth

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18955

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Samuel Johnson Spicer, Sr.

2. Date of Death Month / Dey / Year: May 11, 2002

3. Time of Death: 0947

4a Facility Neme *(If not institution, give street and number)*: Upper Chesapeake Medical Center

4b. City, Town, or Location of Deeth: Bel Air

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 217-24-9936

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr. 6, 1929

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1407 Philadelphia Road

10f. Zip Code: 21085

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Equipment Specialist

16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Arlie Washington Spicer

18. Mother's Name *(First, Middle, Maiden Surname)*: Beatrice Attie Caudill

19a. Informant's Name/Relationship *(Type, Print)*: James D. Spicer/ Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1407 A Philadelphia Road, Joppa, MD 21085

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Zion Evan. Lutheran Cem.

Date: 5-14-02

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Stephen A Keech

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute and Chronic Respiratory Failure — years

Due to (or es a consequence of):

b. Congestive Heart Failure — years

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertention — years

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physicien**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Albert S.C. Sun, M.D.

29c. License number: D0018779

29d. Date signed *(Month, Day, Year)*: May 21, 2002

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Albert S.C. Sun, M.D. 1716 Harford Rd., Suite 105, Fallston, MD 21047

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 24 2002

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detechedfor use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18956

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Lillian Elizabeth Suman | MAY 24, 2002 | 6:18 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SAINT JOSEPH MEDICAL CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-12-5452 | 1☐ M 2☒ F | 77 Yrs. | | | 09/17/1924 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Bel Air | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1301 Cherokee Lane | 21015 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9th | | Cashier | Grocery |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Elijah W. Simms, Sr. | Annie G. Kramer |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Carroll L. Suman, Sr./Husband | 1301 Cherokee Lane, Bel Air, Maryland 21015 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Parkwood Cemetery | 05/28/2002 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Brian A. Weller | The Schimunek Funeral Home 610 W. MacPhail Road, Bel Air, Maryland 21014 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. STATUS POST CARDIAC BYPASS SURGERY — DAYS

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONERY ARTERY DISEASE

ATHEROSCLEROSIS

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒ Yes 2☐ No | 1☒ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Taqi | D28244 | 5-25-02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FOWZIA TAQI, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 28 2002 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2002 18957

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOHN (UNK) SEROKA
2. Date of Death (Month, Day, Year): May 25, 2002
3. Time of Death: 8:30 P.M.
4a. Facility Name (If not institution, give street end number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 182-03-5144
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 2, 1917
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1503 Scarlet Oak Court
10f. Zip Code: 21014
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hairdresser
16b. Kind of Business/Industry: Beauty & Hair Care

17. Father's Name (First, Middle, Last): Andrew (nmn) Seroka
18. Mother's Name (First, Middle, Maiden Surname): Anna (nmn) Belanik

19a. Informant's Name/Relationship (Type, Print): Suzanne A. Welsh - Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1503 Scarlet Oak Court, Bel Air, Maryland 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Royal Palm Memorial Grdns
Date: 5/30/02
20c. Location - City or Town, State: W. Palm Beach, FL

21. Signature of Funeral Service Licensee: Stella A Keech
22. Name and Address of Facility: McComas Funeral Home P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | SEPSIS | 4 DAYS |
| Due to (or as a consequence of): b. | PNEUMONIA | 1 WEEK |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | CHRONIC OBSTRUCTIVE PULMONARY DISEASE | 5 YEARS |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE, CORONARY ARTERY DISEASE, CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: PHYSICIAN
29c. License number: D53590
29d. Date signed (Month, Day, Year): MAY 29 2002
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SUONEN DY, MD 1830 EAST MONUMENT ROOM 8033 BALTIMORE MD 21205

**State Registrar**

31. Date filed (Month, Day, Yeer): MAY 28 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18958

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Kathryn Louise Schultz
2. Date of Death (Month, Day, Year): May 27, 2002
3. Time of Death: 2:35 P M
4a. Facility Name (If not institution, give street and number): 5 Perry Falls Place
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-56-4430
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 50 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 2, 1952
9. Birthplace (State or Foreign Country): Pennsylvania

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 5 Perry Falls Place
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Morgan Kenney
18. Mother's Name (First, Middle, Maiden Surname): Lucille Schaefer

19a. Informant's Name/Relationship (Type, Print): Damian R. Schultz (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Perry Falls Place, Baltimore, MD 21236

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 5/30/02
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

LM

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Cancer lung — Approximate Interval Between Onset and Death: 7 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D18487
29d. Date signed (Month, Day, Year): 5/28/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MYO THANT 8114 SANDPIPER CIRCLE, BALTO, MD 21236

12

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: [signature]

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2002 18959

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: WILLIAM ROBERT SICCA

2. Date of Death Month Day Year: MAY 28 2002

3. Time of Death: 0210 AM M

4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-26-7103

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 28, 1938

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 311 Still Meadow Drive

10f. Zip Code: 21085

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Painter

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Anthony (u/k) Sicca

18. Mother's Name *(First, Middle, Maiden Surname)*: Evelyn (u/k) Knisley

19a. Informant's Name/Relationship *(Type, Print)*: Grace A. Moon - Friend

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 311 Still Meadow Drive, Joppa, Maryland 21085

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp.

Date: 5-31-02

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Stephen A Dench

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. GANGRENE OF FEET AND HANDS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other *(specify)* 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Timothy Low M.D.

29c. License number: D24034

29d. Date signed *(Month, Day, Year)*: 5/28/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TIMOTHY LOW M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: MAY 30 2002

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

2002 18960

Reg. No.

**Physician /Medical Examiner**

**Funeral Director**

1. Decedent's Name (First, Middle, Last): Garnett Elizabeth Smullen
2. Dete of Deeth: Month May Day 29 Year 2002
3. Time of Death: 13:48
4e. Fecility Neme (If not institution, give street end number): Dorchester General Hospital
4b. City, Town, or Location of Death: Cambridge
4c. County of Deeth: Dorchester
5. Social Security Number: 214-60-9110
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthdey): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Jan. 11, 1953
9. Birthplace (State or Foreign Country): Maryland
Usuel Residence of Decedent
10a. Stete: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street end Number: 618 Schoolhouse Lane
10f. Zip Code: 21613
10g. Citizen of What Country?: USA
11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Nursing Assistant
16b. Kind of Business/Industry: Nursing Home
17. Fether's Neme (First, Middle, Last): Emerson Leroy Smullen
18. Mother's Name (First, Middle, Maiden Surname): Doris Jean Anderson
19a. Informant's Name/Relationship (Type, Print): Victoria Smullen
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 203 Choptank Ave, Cambridge, Maryland 21613
20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Waugh Cemetery
Date: 6/5/02
20c. Location - City or Town, State: Cambridge, Maryland
21. Signature of Funeral Service Licensee: Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St. Cambridge, Maryland 21613

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) e. | Intracerebral hemorrhage | 3 Days |
| Due to (or as e consequence of): b. | Hypertension | unknown |
| Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last: Due to (or es e consequence of): c. | | |
| Due to (or es e consequence of): d. | | |

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal failure

23b. Did tobacco use contribute to the cause of deeth? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Signature end title of certifier: [signature], M.D.

29c. License number: D50804

29d. Date signed (Month, Dey, Yeer): 5-29-02

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Mark Malkus, M.D. 408 Byrn Street Cambridge, MD 21613

**State Registrar**

31. Date filed (Month, Day, Year): MAY 31 2002

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18961

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Agnes A. Thompson
2. Date of Death — Month: May Day: 31, Year: 2002
3. Time of Death: 4:35P M
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 230-42-1229
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jun. 7, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12045 Route 144
10f. Zip Code: 21042
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Bus Aid
16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): John Barth
18. Mother's Name (First, Middle, Maiden Surname): Lilly Mae Porter

19a. Informant's Name/Relationship (Type, Print): Barbara Ely/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12045 Route 144 Ellicott City, MD 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. View Cemetery
Date: 06/05/2002
20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: Steven Collins MO1044
22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. COPD
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death: years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cirrhosis
Pancreatitis

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown
24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D0044362
29d. Date signed (Month, Day, Year): June 3, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ENRICO A. GIANGERUSO, MD 200 MEMORIAL AVE. WESTMINSTER MD 21157

**State Registrar**

31. Date filed (Month, Day, Year): JUN 04 2002
32. Registrar's Signature: [signature]

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AGNES ALINE THOMPSON

6

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18962

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Catherine T. Vaughan

2. Date of Death: Month: MAY Day: 28 Year: 2002

3. Time of Death: 11:27 PM

4a. Facility Name (If not institution, give street and number): LORIEN @ RIVERSIDE

4b. City, Town, or Location of Death: BELCAMP

4c. County of Death: HARFORD

**Funeral Director**

5. Social Security Number: 190-10-2699

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 6, 1917

9. Birthplace (State or Foreign Country): Pennsylvania

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 332 Carter Street

10f. Zip Code: 21001

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: In Home

17. Father's Name (First, Middle, Last): Joseph Laeng

18. Mother's Name (First, Middle, Maiden Surname): Marie Blank

19a. Informant's Name/Relationship (Type, Print): William M. Vaughan (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1271 Courtney Lane, Belcamp, MD 21017

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): R.A.Ferris & Co.

Date: 5/30/02

20c. Location - City or Town, State: West Chester, PA

21. Signature of Funeral Service Licensee: Kirsten Amy Unglesbee

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Catherine Vaughan

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. End Stage Alzheimers disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: 027975

29d. Date signed (Month, Day, Year): 5/29/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shawn McClure MD 615 Macphail rd Bel Air MD 21014

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002

32. Registrar's Signature: [signature] G Sparks

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18963

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JEWELL WARD

2. Date of Death: Month 06 Day 01 Year 02

3. Time of Death: 10-20 PM

4a. Facility Name (If not institution, give street and number): Lorien Nursing Home

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 266-76-2271

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 25, 1910

9. Birthplace (State or Foreign Country): Florida

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3837 Dahlgren Court

10f. Zip Code: 21042

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): John N. Maige

18. Mother's Name (First, Middle, Maiden Surname): Mary Crowder

19a. Informant's Name/Relationship (Type, Print): Jerry M. Ward/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3837 Dahlgren Court Ellicott City, MD 21042

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 06/03/2002

20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: Dan Collins-Wilt M01044

22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIORESPIRATORY ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CVA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bunyan Vadoo

29c. License number: D0058192

29d. Date signed (Month, Day, Year): 6/2102

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3060 MITCHELVILLE ROAD #103 BOWIE, MD 20716

**State Registrar**

31. Date filed (Month, Day, Year): JUN 04 2002

32. Registrar's Signature

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18964

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John Bernard Wilson

2. Date of Death: Month May, Day 18, Year 2002

3. Time of Death: 7:50 PM

4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 194-05-9220

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 6, 1910

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2525 Pot Spring Road

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1943-44

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Internal Revenue Officer

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Hugh Sylvester Wilson, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Bell McDougall

19a. Informant's Name/Relationship (Type, Print): Rita C. Garrity / Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 725 Rainbow Court, Edgewood, MD 21040

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet.

Date: 5-24-02

20c. Location - City or Town, State: Owings Mills, Maryland

21. Signature of Funeral Service Licensee: Stanley A Keech

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: J W Kr

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T Jiang

29c. License number: D54967

29d. Date signed (Month, Day, Year): 5/23/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy T. Jiang, MD, 6701 N. Charles Street, Suite 3853, Baltimore, MD 21204

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

31. Date filed (Month, Day, Year): MAY 24 2002

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18965

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Barbara Berry Webb | May 8, 2002 | 6:10 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Suburban Hospital | Bethesda | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 372-20-8173 | 1☐ M 2☒ F | 78 Yrs. | | | Aug. 31, 1923 | Iowa |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Bethesda | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9707 Old Georgetown Road, #2519 | 20814 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Homemaker | Domestic (Own Home) |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Julius Berry | Marie Purdy |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Susan Webb Soltys (Daughter) | 2423 W. 16th St., Wilmington, Delaware 19806 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Chesapeake Crematory | May 13, 2002 | Beltsville, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Kevin A. Sparks mo26 | Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, Md. 20910 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Anoxic Brain Injury | 2 Days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Asystole | 2 Days |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Insufficiency

Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Joseph R. Fontana, MD | 50718 | May 9, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph R. Fontana, M.D.; 8600 Old Georgetown Rd., Bethesda, Md. 20814

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| MAY 16 2002 | ▶ Kevin A. Sparks |

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Webb, Barbara 518102 0610AM

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18966

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William E. Yingling
2. Date of Death (Month, Day, Year): MAY 28, 2002
3. Time of Death: 11:44PM

4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-34-0739
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 28, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2924 E. Northern Parkway
10f. Zip Code: 21214
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technician
16b. Kind of Business/Industry: A.T.&T Communications

17. Father's Name (First, Middle, Last): William E. Yingling, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Paulus

19a. Informant's Name/Relationship (Type, Print): Mrs. Carol A. Yingling (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2924 E. Northern Parkway, Baltimore, MD 21214

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 6/1/02
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian A. Miller
22. Name and Address of Facility: Schimunek Funeral Homes, 9705 Belair Rd., Baltimore, MD 21236

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

Yingling WM

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Hepatic Encephalopathy | 1 week |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | Alcoholic Cirrhosis | 3 yrs |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

LM

If FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D57444
29d. Date signed (Month, Day, Year): May 29, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alexander W. Chen MD 6701 N. Charles St., Towson, MD 21204

15

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

**State Registrar**

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#7,8 perFHG808 6/13/02 EW

# Certificate of Death

Reg. No. 2002 18967

**Physician /Medical Examiner**

**Funeral Director**

1. Decedent's Name (First, Middle, Last): CIARA E. ADAMS

2. Date of Death: Month June Day 6 Year 2002

3. Time of Death: 6:15 AM

4a Facility Name (If not institution, give street and number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

5. Social Security Number: 216-25-3900

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): ~~96~~ 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4 9 1907

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 201 N Washington Street

10f. Zip Code: 21231

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maid

16b. Kind of Business/Industry: Store Kaufman's Furn.

17. Father's Name (First, Middle, Last): Jeremiah Chambers

18. Mother's Name (First, Middle, Maiden Surname): Estella Rhodes

19a. Informant's Name/Relationship (Type, Print): Mary O. Nasibi Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2091 95 E. Wayne Avenue Apt. 110 Silver Spring MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Calvary Cemetery

Date: 6-14-02

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: Gladys Warner

22. Name and Address of Facility: BALTIMORE MARYLAND 21202 MARCH F.H. EAST 1101 E. NORTH AVENUE

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: CVergara Soares MD

29c. License number: D16619

29d. Date signed (Month, Day, Year): June 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. VERGARA-SOARES 1601 E. BELVEDERE AVE. BALTIMORE, MD. 21239

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002

32. Registrar's Signature: Steven B Spears

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18968

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ADAM A. ANDRYSZAK
2. Date of Death: Month JUNE Day 11, Year 2002
3. Time of Death: 6:20 AM
4a. Facility Name (If not institution, give street and number): CHARLESTOWN CARE CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-14-9348
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 24, 1924
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: LINTHICUM
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 6121 MEDORA ROAD
10f. Zip Code: 21090
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DRAFTSMAN
16b. Kind of Business/Industry: ELECTRICIAL APPLIANCES

17. Father's Neme (First, Middle, Last): ADAM ANDRYSZAK
18. Mother's Name (First, Middle, Maiden Surname): MARY GRAWOWSKI

19a. Informant's Name/Relationship (Type, Print): JOHN A. ANDRYSZAK (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7806 GOLDEN PINE CIRCLE, SEVERN, MARYLAND 21144

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK
Date: JUNE 14, 2002
20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee: Paul E. Hagan
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. Myocardial Infarction — minutes

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier: MD
29c. License number: D 47447
29d. Date signed (Month, Day, Year): JUN 11 2002

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Andrew Tyris 711 Maiden Choice Lane Catonsville MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002
32. Registrar's Signature: Bonnie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: if item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law raquiras that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18969

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Elizabeth V. Aro
2. Date of Death (Month, Day, Year): June 11, 2002
3. Time of Death: 8:00 PM
4a. Facility Name (If not institution, give street and number): 5725 First Ave.
4b. City, Town, or Location of Death: Halethorpe, MD. 21227
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-24-4237
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 22, 1930
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Halethorpe
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5725 First Ave.
10f. Zip Code: 21227
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): Emma Coppage

19a. Informant's Name/Relationship (Type, Print): Darlene Jean Brooks, daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5725 First Ave. Halethorpe, MD. 21227

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 06-12-02
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CANCER of URINARY
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
INSULIN DEPENDENT DIABETES
CROHN'S DISEASE
HYPOMAGNESEMIA

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] B. STINCHCOMB MD
29c. License number: 045352
29d. Date signed (Month, Day, Year): 6/12/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN STINCHCOMB 8827 COLUMBIA 100 PARKWAY, SUITE 2, COLUMBIA MD 21045

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002
32. Registrar's Signature: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

RR

RR 10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18970

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Xavier Paul Anderson
2. Date of Death: Month 6 Day 1 Year 02
3. Time of Death: 0030
4e. Facility Name (If not institution, give street and number): Prince Georges Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: unk
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): Yrs.; If Under 1 Year: Months, Days 3; If Under 24 Hrs.: Hours 3, Min. 50
8. Date of Birth (Month, Day, Year): 5 29 02
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 8107 Manson Street
10f. Zip Code: 20785
10g. Citizen of Whet Country?: USA
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: black
15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): none; College (1-4or 5+): none
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none
16b. Kind of Business/Industry: none
17. Father's Neme (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): Dorine Anderson
19a. Informant's Name/Relationship (Type, Print): Prince Georges Hospital
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): unk
20e. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify): in state
20b. Place of Disposition (Neme of cemetery, cremetory or other place):
Date:
20c. Location - City or Town, State:
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)
e. PULMONARY HEMORRHAGE

Due to (or es e consequence of):
b. ANEMIA

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

Due to (or as e consequence of):
c. INTRAVENTRICULAR HEMORRHAGE

Due to (or es e consequence of):
d. EXTREME PREMATURITY

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [illegible] M.D.
29c. License number: D16239
29d. Date signed (Month, Day, Year): 6/01/02

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): ANTOINE K. FOMUFOD M.D. 3001 HOSPITAL DRIVE, Cheverly, Md. 20785

**State Registrar**

31. Dete filed (Month, Day, Year): JUN 13 2002
32. Registrer's Signature: [illegible]

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funerel director, pege 2 should be detached for use es the buriel-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18971

Physician /Medical Examiner

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| PATRICIA | BLACK | JUNE 9 2002 | 10:50p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2410 Pinewood Avenue | Baltimore | NA |

Funeral Director

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-36-6610 | 1☐ M 2☒ F | 59 Yrs. | | | 11 4 42 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2410 Pinewood Avenue | 21214 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10th grade | | Self Employed | Store Owner |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Garfield Randolph | Myrle Jones |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia Brown Daughter | 2410 Pinewood Avenue Balto. Maryland 21214 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | King Memorial PK | 6-14-02 | Randallstown MD |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility BALTIMORE MARYLAND 21202
MARCH F.H. EAST 1101 E. NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. metastatic Lung cancer | 3 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:

| 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] M.D. | D 44944 | June 10, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stanley Walker 3333 North Calvert Street Baltimore md 21218

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | [signature] |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

02-3100-510
B.K.S
SEYMOUR BORISH

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18972

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| SEYMOUR | BORISH | JUNE 10, 2002 | 10:30A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3816 MIDHEIGHTS ROAD | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-24-9971 | 1 X M 2 ☐ F | 75 Yrs. | | | FEB 6 1927 | MD. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3816 MIDHEIGHTS ROAD | 21215 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | CLERK | FOOD SERVICE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| MYER BORISH | FANNIE KLAWANSKY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| PAULINE SCHUMAN/SISTER-IN-LAW | 3021 FALLSTAFF ROAD APT. 103 BALTIMORE, MD. 21209 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory, other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | ARLINGTON CHEVRA AMUNO CONGREGATION | 6/12/2002 | BALTIMORE,MD. |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Hypertensive Arteriosclerotic | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. X Cardiovascular Disease | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Parkinson's Disease

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): JUNE 10, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. ARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18973

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| MARILYN | A. | COVER | JUNE 10, 2002 | 3:00 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 7906 OAKWOOD ROAD | GLEN BURNIE | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-14-4466 | 1☐M 2☒F | 80 Yrs. | | | MAR. 26, 1922 | NEW YORK |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | GLEN BURNIE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7906 OAKWOOD ROAD | 21061 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| WILLIAM GROW | AUGUSTA H. STOCKHAUSEN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MARILYN A. BURKETT (DAUGHTER) | 1011 SHARON DRIVE, GLEN BURNIE, MD. 21061 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) | ENTOMBMENT LOUDON PARK CEMETERY | JUNE 14, 2002 | BALTIMORE, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Paul D Hagan | SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Emphysema | 10 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Coronary Artery Disease | 2 years |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☑No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Elliott Gotlieb MD | D20074 | 06/11/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Elliott Gotlieb MD 7845 Oakwood Rd., Glen Burnie, Md, 21061

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | ▶ Penny D Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2002 18974

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): Patricia Cole | | | 2. Date of Death Month: June Day: 09 Year: 2002 | | | 3. Time of Death: 11:50 AM | |
| 4a. Facility Name (If not institution, give street end number): Prince George County Hospital | | | 4b. City, Town, or Location of Death: Cheverly | | | 4c. County of Death: Prince George | |
| 5. Social Security Number: 578-64-3091 | 6. Sex: 1☐ M 2☒ F | 7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year): Dec 9,1948 | 9. Birthplace (State or Foreign Country): Washington DC | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State: Maryland | 10b. County: Charles | 10c. City, Town or Location: Waldorf | | | | 10d. Inside City Limits: 1☒ Yes 2☐ No | |
| 10e. Street and Number: 322 Woodside Place | | 10f. Zip Code: 20601 | | | | 10g. Citizen of Whet Country?: United States | |
| 11. Marital Stafus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, efc.): 1☐ Yes 2☒ No Specify: Black | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Educefion (Specify only highest grede completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 2 | | 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Telemarketer | | | | 16b. Kind of Business/Industry: Nightwatch Security | |
| 17. Fether's Neme (First, Middle, Lest): James Moore | | 18. Mother's Name (First, Middle, Maiden Surname): Evelyn May | | | | | |
| 19a. Informant's Name/Relationship (Type, Print): Frank Cole Jr | | 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 322 Woodside Pl, Waldorf, MD 20601 | | | | | |
| 20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | | 20b. Piece of Disposition (Name of cemetery, crematory or other piece): Lee Crematory | | Date: 6/12/02 | | 20c. Location - Cify or Town, State: Clinton,Maryland | |
| 21. Signature of Funeral Service Licensee: John T Bolt | | 22. Name and Address of Facility: Robert G. Mason Funeral Home 1661 Good Hope Rd SE Wash DC 20020 | | | | | |

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death)
e. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiafed events resulting in death) Last
b. Respiratory Failure

Due to (or es a consequence of):

c.

Due to (or as e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☒ **Unknown**

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as steted.
2☐ **Medical Examiner**: On the besis of examination and/or investigation, in my opinion, deafh occurred et the time, date and place, and due to the cause(s) and manner steted.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| Steven Schwartz MD | D0053850 | June 9, 2002 |

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print): Steven Schwartz MD 3001 Hospital Drive,Cheverly, MD 20785

State Registrar

| 31. Dafe filed (Month, Dey, Year) | 32. Registrer's Signeture |
|---|---|
| JUN 13 2002 | Peggy B Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18975

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Concetta M. Diamond | JUNE 10, 2002 | 9:10 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Saint Joseph Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-34-8689 | 1☐M 2☒F | 64 Yrs. | | | July 20,1937 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Kingsville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11203 Pfeffers Road | 21087 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Homemaker | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Santo V. Alascio | Angelina D. LaMartina |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Santo W. Diamond:Son | 11203Pfeffers Road Kingsville,Maryland21087 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Bel Air MemorialGardens | 6/14/02 | BelAir,Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael P. Marzullo | Marzullo Funeral Service 3981Carrollton Road Upperco,Maryland21155 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | 1 WEEK |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. GANGRENE OF LEFT FOOT | 2 WEEKS |
| | Due to (or as a consequence of): c. CORONARY ARTERY BYPASS GRAFT | 3 MONTHS |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ A. J. Helou, M.D. | D17695 | June 10, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH J. HELOU, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | Bonnie B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18976

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EUGENE DELGADO
2. Date of Death (Month, Day, Year): JUNE 02 2002
3. Time of Death: 12:21 PM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: 728-09-9317
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 9, 1912
9. Birthplace (State or Foreign Country): Puerto Rico

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9109 Liberty Road
10f. Zip Code: 21133
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: unk
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] Yes 2 [ ] No Specify: Puerto Rican
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): teacher
16b. Kind of Business/Industry: education

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Northwest Hospital
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5401 Old Court Road Randallstown, MD 21133

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — Approximate Interval Between Onset and Death: 2 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): BILATERAL PNEUMUNIA — 2 WEEK.
c. Due to (or as a consequence of): CONGESTIVE HEART FAILURE — 2 WEEK.
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ENDSTAGE COPD

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D 0055481
29d. Date signed (Month, Day, Year): JUNE 02 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHWE GYAW 5401 OLD COURT ROAD RANDALLSTOWN MD 21133

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002
32. Registrar's Signature: Shawna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #20a PER FH G8086/13/02 SH

# Certificate of Death

Reg. No. 2002 18977

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANNIE MAE EWELL
2. Date of Death (Month, Day, Year): JUNE 6 2002
3. Time of Death: 3:11 AM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213 20 6216
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 10, 1925
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 4000 OAKFORD AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S. OF A.

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 9TH
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSE KEEPER
16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): EDWARD BOGUES
18. Mother's Name (First, Middle, Maiden Surname): CORA CLARA

19a. Informant's Name/Relationship (Type, Print): BARBARA BAILEY (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4000 OAKFORD AVENUE BALTIMORE, MD. 21215

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory, or other place): METRO CREMATORY
Date: 6/11/02
20c. Location - City or Town, State: CATONSVILLE, MD.

21. Signature of Funeral Service Licensee: LEWIS T. GWYNN — Lewis T. Gwynn
22. Name and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO., MD.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — 1 WEEK
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. PNEUMONIA — 2 WEEKS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PERIPHERAL VASCULAR DISEASE
GANGRENE, OSTEOMYELITIS OF RIGHT FOOT

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one) Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MATTHEW OLNES
29c. License number: RES-000
29d. Date signed (Month, Day, Year): JUNE 6, 2002
30. Name and Address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW OLNES, MD 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002
32. Registrar's Signature: Barbara B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RF

RF 3

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item#23a per Phyg808 6/18/02 EW

# State of Maryland / Department of Health and Mental Hygiene
## Certificate of Death

Reg. No. 2002 18978

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ERNESTINE EDWARDS
2. Date of Death Month/Day/Year: 06/05/2002
3. Time of Death: 08:45 PM

4a. Facility Name (If not institution, give street and number): BON SECURE HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 217-14-3508
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR. 26, 1923
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 4509 ROKEBY ROAD
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FACTORY WORKER
16b. Kind of Business/Industry: CONTINENTIAL CAN

17. Father's Name (First, Middle, Last): JOSEPH SCOTT
18. Mother's Name (First, Middle, Maiden Surname): MAMIE SCOTT

19a. Informant's Name/Relationship (Type, Print): BARBARA E. CONNOR (NIECE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4509 ROKEBY ROAD BALTIMORE, MD 21229

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CROWNSVILLE VET. CEM
Date: 6/11/02
20c. Location - City or Town, State: CROWNSVILLE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Acute gastro intestinal bleeding.
Due to (or as a consequence of): GASTRIC ULCER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death:

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
End stage renal disease, Stridor due to edema of the larynx.
Breast cancer
Diabetes mellitus
Pneumonia
Myocardial infarction

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: 047804
29d. Date signed (Month, Day, Year): 06/06/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1940 W. Baltimore St. Baltimore MD 21223

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002
32. Registrar's Signature: [signature] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18979

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): RUTH FISCHER

2. Date of Death: Month June, Day 12, Year 2002

3. Time of Death: 0630 AM

4a. Facility Name (If not institution, give street and number): Cherry lane Nursing Center

4b. City, Town, or Location of Death: Laurel

4c. County of Death: PG

5. Social Security Number: 536-16-2761

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 6, 1913

9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 9001 Cherry Lane

10f. Zip Code: 20708

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Wilson

18. Mother's Name (First, Middle, Maiden Surname): Zoe Bayha

19a. Informant's Name/Relationship (Type, Print): Michael Riley/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10739 Tucker Street Beltsville, MD 20705

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 6-13-02

20c. Location - City or Town, State: Baltimore, MD

21. Signature of ~~Funeral Service Licensee~~: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimers disease

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 43351

29d. Date signed (Month, Day, Year): 6/12/02.

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Dr. Ikechi Fred Okwara 6201 Greenbelt Rd, Suite U-15, College PK MD 20740

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JUN 13 2002

32. Registrar's Signature: Bonnie L. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18980

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret, E, Guerke
2. Date of Death (Month, Day, Year): June 11 2002
3. Time of Death: 5:27 PM
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 163-24-7160
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/20/28
9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7571 BALTIMORE & ANNAPOLIS BLVD.
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PERSONNEL SUPERVISOR
16b. Kind of Business/Industry: DEPARTMENT STORE

17. Father's Name (First, Middle, Last): CHARLES TRIMBATH
18. Mother's Name (First, Middle, Maiden Surname): MARY BOOKSHAR

19a. Informant's Name/Relationship (Type, Print): (HUSBAND) MR. FRANCIS G. GUERKE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7571 B & A BOULEVARD, GLEN BURNIE, MD. 21060

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATION CENTER, LLC
Date: JUNE 12, 2002
20c. Location - City or Town, State: STEVENSVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ Michele N Vehula MO1241
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. pancreatic cancer — 15 months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b. shock — 24 hours
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
anemia

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ John F. Wiley MD
29c. License number: D42388
29d. Date signed (Month, Dey, Year): 6/11/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Wiley MD 200 Hospital Dr. #409, Glen Burnie, MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002
32. Registrar's Signature: Barbara B Sparks

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Guerke, Margaret

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18981

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John James

2. Date of Death: Month June, Day 9, Year 2002

3. Time of Death: 1855

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 049-82-4813

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 29 Yrs.

If Under 1 Year: Months, Days

If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): 4 23 73

9. Birthplace (State or Foreign Country): Conn.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 4402 Chalet Court Apt 2-B

10f. Zip Code: 21206

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Never Employed

16b. Kind of Business/Industry: NA

17. Father's Name (First, Middle, Last): John W. James Jr.

18. Mother's Name (First, Middle, Maiden Surname): Carrie Taylor Edwards

19a. Informant's Name/Relationship (Type, Print): Carrie Taylor Edwards Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4402 Chalet Court Apt.3-C Balto. MD 21206

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Zion Cemetery

Date: 6-14-02

20c. Location - City or Town, State: Dundalk Maryland

21. Signature of Funeral Service License: ▶ [signature]

22. Name and Address of Facility: BALTIMORE MARYLAND 21202 MARCH F.H. EAST 1101 E. NORTH AVENUE

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Glioblastoma multiforme | 3 months |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Lung transplant | 3 months |
| Due to (or as a consequence of): | | |
| | c. Scleroderma | 29 years |
| Due to (or as a consequence of): | | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: RES-001

29d. Date signed (Month, Day, Year): June 9, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Kuperman, MD 600 North Wolfe Street Baltimore, Maryland 21205

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18982

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JAMES JACKSON JR | JUNE 1, 2002 | 10:45 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2224 Round Road #T1 | Brooklyn | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| unk | 1[X] M 2[ ] F | 57 Yrs. | | | Apr 7, 1945 | Mississippi |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Brooklyn | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2224 Round Road #T1 | 21225 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[ ] Never Married 2[ ] Married 3[ ] Widowed 4[X] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | unk | warehouse |
| 7 | 0 | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Jackson | unk |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Larry Donnerson/brother | 2520 E. Hoffman Street Baltimore, MD 21213 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[ ] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[X] Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Renal Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acquired Immunodeficiency Syndrome

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown

23c. If yes, outcome of pregnancy 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[/] Unknown

24a. Was an autopsy performed? 1[ ] Yes 2[/] No

24b. Were autopsy findings available prior to completion of cause of death? 1[ ] Yes 2[ ] No

25. Was case referred to medical examiner? 1[ ] Yes 2[/] No

26. Place of Death (Check only one)

Hospital: 1[ ] Inpatient 2[/] ER/Outpatient 3[ ] DOA

Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death 1[/] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1[ ] Yes 2[ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1[/] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D40854 | Jun 5 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Risebergs 301 St Paul Pl Baltimore 21202

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 | 8933

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LORRAINE EVELYN JACKSON
2. Date of Death (Month, Day, Year): JUNE 3, 2002
3. Time of Death: 10:00 PM
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 186-16-4410
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 11, 1921
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Forest Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1613 Michelle Court
10f. Zip Code: 21050
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): housewife
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Emmett Farrell Culver
18. Mother's Name (First, Middle, Maiden Surname): Nora Allen

19a. Informant's Name/Relationship (Type, Print): Marguerite Purcell/sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 Fulford Avenue Bel Air, MD 21014

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) / Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

JUNE 3, 2002 10:10 p.m.

LORRAINE JACKSON

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ESOPHOGEAL CANCER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D43725
29d. Date signed (Month, Day, Year): 6/4/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LORRAINE JACKSON

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002
32. Registrar's Signature: Bruce B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2002 18984

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): RONALD B. KRAUSS, SR.
2. Date of Death: Month 6 Day 11 Year 2002
3. Time of Death: 1610

4a. Facility Name (If not institution, give street and number): 234 TEAL CIRCLE
4b. City, Town, or Location of Death: OCEAN PINES
4c. County of Death: WORCESTER

**Funeral Director**

5. Social Security Number: 219-38-2288
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-9-41
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: OCEAN PINES
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 234 TEAL CIRCLE
10f. Zip Code: 21811
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1960-1962
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HVAC
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): GEORGE A. KRAUSS
18. Mother's Name (First, Middle, Maiden Surname): ANNA ENGLES

19a. Informant's Name/Relationship (Type, Print): JOAN C. KRAUSS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 234 TEAL CIRCLE OCEAN PINES, MD. 21811

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 06-15-02
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Robert Parkinson
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION — IMMEDIATE
Due to (or as a consequence of):
b. CAD — FEW YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HEAVY SMOKER

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dorothy C. Holzworth, M.D.
29c. License number: D 06241
29d. Date signed (Month, Day, Year): 6-13-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DOROTHY C. HOLZWORTH M.D. 203 SNOW ST. SNOW HILL, MD. 21863

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 10

Gary Orlando Lewis, Sr.
02-3057-510
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061402:ITEMS# 23a,27,28a-f per ME SS

# Certificate of Death

Reg. No. 2002 18985

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| GARY ORLANDO LEWIS , SR. | June 08 2002 | 2:50 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214 70 9654 | 1 ☒ M 2 ☐ F | 42 Yrs. | | | JUN.30,1959 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | HOWARD | COLUMBIA | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9286 PIGEONWING PLACE | 21045 | U.S. OF A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12TH | N/A | UNEMPLOYED | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| GORDON LEWIS | EDNA SHERROD |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| EDNA HALL (MOTHER) | 9286 PIGEONWING PLACE COLUMBIA,MD. 21045 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | COLUMBIA MEMORIAL PARK | 6/12/02 | CLARKSVILLE,MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Lewis T. Gwynn | LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVE. BALTO.,MD. |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. HEROIN INTOXICATION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| Found: 6-8-02 | Found: 1:30a M | 1 ☐ Yes 2 ☒ No | Unknown |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 2609 Keyworth Ave., Baltimore, MD

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | O.C.M.E. | June 08, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AAmend Item 11
PER IFM G812 10/18/02 RR

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #27 &30 PER PHY G808 6/19/02 JH

# Certificate of Death

Reg. No. 2002 18986

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ROYAL V. MCKENNA | June 4, 2002 | 1710 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Memorial Hospital | Easton | Talbot |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 059-24-3524 | 1 X M 2 ☐ F | 76 Yrs. | | | Feb 17, 1926 | New York |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Talbot | Easton | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 703 Summer Place | 21601 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 X Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates: '44-46 | 1 ☐ Yes 2 X No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | self employed | unk |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Donald E. McKenna | Grace A. Crow |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary McKenna/daughter | 5307 Ferryneck Road Royal Oak, MD 21662 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Heart Disease
CHF

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

| 24a. Was an autopsy performed? 1 ☐ Yes 2 X No | 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No |
|---|---|

| 25. Was case referred to medical examiner? 1 ☐ Yes 2 X No | 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Faith J. Mathjani DO | H0053775 | June 4, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FAITH J. JABERS -MATZONI, DO MEMORIAL HOSPITAL 219 S. WASHINGTON ST. EASTON MD. 21601

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | Barbara G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Royal McKenna

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18987

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| FRANCIS | LARRY | MARVEL | JUNE 11, 2002 | 5:45 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 759 214TH STREET | PASADENA | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-38-7398 | 1 [X] M 2 [ ] F | 61 Yrs. | | | Dec 23, 1940 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Pasadena | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 759 214th Street | 21122 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1960-64 | 1 [ ] Yes 2 [X] No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Firefighter | Fire Department |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frank L. Marvel Jr. | Hazel Turner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Marvel - wife | 759 214th Street, Pasadena, MD 21122 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Maryland Veterans | Jun 14 2002 | Crownsville, MD |

21. Signature of Funeral Service Licensee: Chris Cody MO1319

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Small Cell Lung Cancer | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. metastatic to Liver | 1 year |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was casa referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Roger Gorbatz MD | 027938 | June 12, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roger Gorbatz MD 795 Aquahart Rd Glen Burnie MD 21061

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | Barbara B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18988

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| TERRY | NELSON | 6 / 9 / 2002 | 9:20a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington Adventist Hospital | Silver Spring | Montgomery Co. |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 057-32-1807 | 1☐ M 2☒ F | 55 Yrs. | | | 3 17 47 | N.Y. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Prince George | Hyattsville | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3340 Lancer Drive Apt. 2 | 20782 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | 4 yrs | Work with Juveniles | Social Worker |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lewis Nelson | Veleena Baylor |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Katrina A. Alexis Daughter | P.O. Box 1156, Kenbridge, Va. 23944 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Mayflower Bapt. Ch | 6/14/02 | Kenbridge, Va. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Joseph R. Walters Jr | March F.H. East, 1101 E. Noeth Ave. Baltimore, Md. 21202 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. BREAST CANCER, | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| tF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant condltions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ R. Muench | D24848 | 06/09/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. RONALD MUENCH 1300 Piccard Dr. #202 Rockville, Md. 20850

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | ▶ G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

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DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Amend Items 11 per FH, 23a,30. per Verb06/13/02dhb,G808

# Certificate of Death

For State Registrar

Reg. No. 2002 18989

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Carl A. Nicely

2. Date of Death: Month May, Day 29, Year 2002

3. Time of Death: 6:00 A.M

4a. Facility Name (If not institution, give street and number): Fort Washington Hospital

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 220-32-5945

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 15, 1934

9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Ft. Washington

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1302 Old Fort Road

10f. Zip Code: 20744

10g. Citizen of What Country?: U.S.A.

11. Marital Status: UNK
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): mail handler

16b. Kind of Business/Industry: U.S. Senate House

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Saye Peele/friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1302 Old Fort Road, Ft. Washington, MD 20744

20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) in-state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Joseph P. Van Sant

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore St. Baltimore, Maryland 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Cirrhosis — months
Due to (or as a consequence of):
c. Hepatic Encephalopathy — days
Due to (or as a consequence of):
d. GI Bleed — days

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____
9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Deep Venous thrombosis
Congestive heart failure

23e. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death
1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Alikhani MD

29c. License number: D46046

29d. Date signed (Month, Day, Year): 5-29-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mirza Alikhani,M.D., Fort Washington Hospital, 11711 Livingston Road, Ft. Washington, MD

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002

32. Registrar's Signature: B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18990

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gary T. Plowden
2. Date of Death: Month 06 Day 04 Year 2002
3. Time of Death: 1100 M
4a. Facility Name (If not institution, give street and number): Maryland Shock Trauma
4b. City, Town, or Location of Death: Baltimore.
4c. County of Death: Baltimore City.

**Funeral Director**

5. Social Security Number: 212-32-6098
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 9, 1934
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 813 E. PRESTON STREET
10f. Zip Code: 21202
10g. Citizen of What Country?: U.S. OF A.

11. Marital Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: KOREAN
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11 TH
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CUSTODIAN
16b. Kind of Business/Industry: STATE OF MARYLAND

17. Father's Name (First, Middle, Last): THEODORE PLOWDEN
18. Mother's Name (First, Middle, Maiden Surname): DOROTHY CURTIS

19a. Informant's Name/Relationship (Type, Print): DELORES PLOWDEN (EX WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 813 E. PRESTON STREET BALTIMORE, MD. 21202

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST VET. CEM. Date: 6/11/02
20c. Location - City or Town, State: BALTO. OWINGS MILLS, MD. Co

21. Signature of Funeral Service Licensee: LEWIS T. GWYNN
22. Name and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO., MD.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Intraventricular Hemorrhage.
Approximate Interval Between Onset and Death: 33 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 X Yes 2 No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: AU 41764 35 K92CC.
29d. Date signed (Month, Day, Year): 06/04/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth Kolasky, UMMS, 22 S. Greene St, Baltimore, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

DR

RR 471

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #18 PER FH G808 6/13/02 JH

# Certificate of Death

Reg. No. 2002 18991

**Physician /Medical Examiner**

**Funeral Director**

1. Decedent's Name (First, Middle, Last): HORTENSE GRACE ROSENBLATT

2. Date of Death (Month, Dey, Yeer): JUNE 9, 2002

3. Time of Death: 6:20 AM

4a. Facility Name (If not institution, give street end number): HOSPICE OF BALTIMORE GILCHRIST CENTER

4b. City, Town, or Location of Daath: TOWSON

4c. County of Deeth: TOWSON

5. Sociel Security Number: 110-12-2851

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthdey): 83 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): JAN.15,1919

9. Birthplece (Stete or Foreign Country): N.Y.

Usuel Residence of Decedent

10a. Stete: FL

10b. County: BROWARD

10c. City, Town or Location: DEERFIELD BEACH

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 2021 BERKSHIRE #B

10f. Zip Code: 33442

10g. Citizen ot Whet Country?: U.S.A.

11. Merital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Dacedant Evar in U,S. Armad Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedant of Hispenic Origin? (Spacify Yes or No- It Yes, specify Cuben, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | Collega (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): SECRETARY

16b. Kind of Business/Industry: ADVERTISING

17. Father's Neme (First, Middle, Last): ABRAHAM WEINTRAUB ~~WEIBTRAUB~~

18. Mother's Name (First, Middle, Maiden Surneme): MINNIE MEYER

19a. Informant's Name/Relationship (Type, Print): ALAN ROSENBLATT / SON

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 3110 MARNAT ROAD - BALTIMORE, MD 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WELLWOOD CEMETERY

Date: 6/9/02

20c. Location - City or Town, State: PINELAWN, N.Y.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part1. Entar tha diseesa, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death) e. pancreatic cancer — 8 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest

b. Due to (or es a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to tha causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) HOSPICE

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner as steted. 2☐ **Medical Examiner**: On the besis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end mannar statad.

29b. Signature end title of certifier: ▶ [signature]

29c. License number: D 58303

29d. Date signed (Month, Day, Yaer): JUNE 9, 2002

30. Name end eddress of person who completed cause ot deeth (Item 23e) (Type, Print): Aaron J. Charles, MD 6601 N. Charles ST, BALTIMORE MD 21204

**State Registrar**

31. Dete filed (Month, Day, Year): JUN 13 2002

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filled within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6 PM 6/9/02 Hortense Rosenblatt 10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2002 18992

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Janet Sabb | | | June | 11 | 2002 | 1040 AM |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | | | |
| University of Maryland | Baltimore | | N/A | | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 219 80 9448 | 1 ☐ M 2 ☑ F | 41 Yrs. | | | | | May 17, 1961 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | N/A | BALTIMORE | 1 ☑ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2813 ROCKROSE AVENUE | 21215 | U.S. OF A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☑ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12TH | N/A | UNEMPLOYED | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| WILLIE JACOB SABB (DECEASED) | QUEEN WILSON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| QUEEN SABB (MOTHER) | 2813 ROCKROSE AVENUE BALTIMORE, MD. 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | MT. ZION CEMETERY | 6/17/02 | LANSDOWNE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| LEWIS T. GWYNN Lewis T. Gwynn | LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO., MD. |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Hemorrhagic Stroke | 1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b. | Coagulopathy | ~1 yr |
| Due to (or as a consequence of): c. | Chronic Hepatitis C | Years |
| Due to (or as a consequence of): d. | | |

RT

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☒ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HIV

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

| 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No | 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No |
|---|---|

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No | 26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |
|---|---|

| 27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Adam I. Weinstein - MD | P15842 | 6/11/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Adam Weinstein 22 S. Green Street Baltimore MD 21201

RR 3

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM #23 PII PER PHY G808 6/13/02 JH

Reg. No. 2002 18993

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Nathan Lewis Smith, Jr.

2. Date of Death Month Day Year: June 8, 2002

3. Time of Death: 6:40PM M

4a. Facility Name (If not institution, give street and number): Glen Meadows Retirement

4b. City, Town, or Location of Death: Glen Arm

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-10-7523

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 11, 1916

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Glen Arm

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11630 Glen Arm Road Apt. 128

10f. Zip Code: 21057

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer

16b. Kind of Business/Industry: Highways

17. Father's Name (First, Middle, Last): Nathan L. Smith

18. Mother's Name (First, Middle, Maiden Surname): Katharine Yeager

19a. Informant's Name/Relationship (Type, Print): Alice K. Reid/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2200 Monkton Road Monkton, MD 21111

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Washington Crematory

Date: June 10, 2002

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: Michael J. Flagle

22. Name and Address of Facility: Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — 1 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia (Alzheimers Type)

~~Hip fracture~~

~~Prostate cancer~~

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M DALY MD

29c. License number: D30433

29d. Date signed (Month, Day, Year): 6/9/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M DALY MD 6701 N CHARLES ST BALTIMORE MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002

32. Registrar's Signature: Bruce B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #19a PER INF. G808 6/18/02 JH **Certificate of Death** Reg. No. 2002 18994

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| WILLIAM | J. | STEVENSON | 6 | 6 | 2002 | 1:00a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Bon Secour Hospital | Baltimore | NA |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | Days | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 217-22-8179 | XX 1☐M 2☐F | 75 Yrs. | | | | | 10 27 26 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | XX☐Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1217 W. Franklin Street | 21223 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| XX 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes XX No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 3rd Grade | | Laborer | Varies |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Stevenson | Marie Woodard |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Amy Scott Kelly ~~Daughter~~ CAREGIVER | 1821 E. 31st Street Baltimore MD 21218 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| XX Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mt Carmel Cem. | 6-13-02 | Dundalk Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Joseph R. Walton Jr | March F.H. East Baltimore, Md. 21202 1101 E. North Ave. |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Atherosclerotic Cardiovascular Disease | 5yrs |
| Due to (or as a consequence of): | b. Recurrent CVA | 5yrs |
| Due to (or as a consequence of): | c. Peripheral vascular Disease | 3yrs. |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ E Ramm | D30641 | June 10 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ramesh Sabapathi 3400 Erdman Avenue Baltimore MD 21213

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2002 18995

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Edith Louise Sternat
2. Date of Death: Month: June; Day: 8; Year: 2002
3. Time of Death: 6:15 PM
4a. Facility Name *(If not institution, give street and number)*: Hammonds Lane Nursing Center
4b. City, Town, or Location of Death: Brooklyn Park
4c. County of Death:

**Funeral Director**

5. Social Security Number: 216-10-0006
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 16, 1913
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Arbutus
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1252 Stevens Avenue
10f. Zip Code: 21227
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Manager
16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: Harry T. Iman
18. Mother's Name *(First, Middle, Maiden Surname)*: Evalena Lantz

19a. Informant's Name/Relationship *(Type, Print)*: Robert D. Iman Brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1310 William Street, Baltimore, MD 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Memorial Park — Date: 6-12-02
20c. Location - City or Town, State: Elkridge, MD

21. Signature of Funeral Service Licensee: Stan P. Turnbull
22. Name and Address of Facility: Ambrose Funeral Home, inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: OLD STROKE; DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D 21776
29d. Date signed *(Month, Day, Yeer)*: JUNE 11 2002

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): SURYA MUNDRA MD 8021 RITCHIE HWY PASADENA MD 21122

**State Registrar**

31. Date filed *(Month, Day, Year)*: JUN 13 2002
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene.
**Important: If Item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18996

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| ANNE | SCHARF | JUNE 11 2002 | 6:43A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SUBURBAN HOSPITAL | BETHESDA | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 130-28-5467 | 1☐M 2☒F | 87 Yrs. | | | FEB 1 1915 | POLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | MONTGOMERY | ROCKVILLE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6111 MONTROSE ROAD | 20852 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | BOOKKEEPER | HANDBAG |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| ISIDORE | BERGER | ROCHELLE | CERESNIE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MR. STEVE SCHARF/SON | 206 WINTERWALK 70-B GAITHERSBURG, MD. 20808 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify) | MT. MORIAH CEMETERY | 6/11/02 | FAIRVIEW, NJ |

21. Signature of Funeral Service Licensee: ▶ Edward C. Rausch

22. Name and Address of Facility: SOL LEVINSON & BROS. INC 8900 REISTERSTOWN ROAD PIKESVILLE,MD.21208

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | 3 hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☑Yes 2☐No | Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ EBernard MD | D35588 | 6/11/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EBernard MD 8600 Old Georgetown Rd Bethesda

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | ▶ Barbara B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Released by ME 6/11/02 0643

Schaf, Anne

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18997

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROVINIA THOMPSON
2. Date of Death (Month, Day, Year): JUNE 9 2002
3. Time of Death: 2:00 P.M
4a. Facility Name (If not institution, give street and number): 2811 EAST BIDDLE STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-16-5599
6. Sex: 1☐ M 2☒F
7. Age (In yrs. last birthday): 97 Yrs.
If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 5, 1905
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2811 EAST BIDDLE STREET
10f. Zip Code: 21213
10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): BEN BAILEY
18. Mother's Name (First, Middle, Maiden Surname): MITTIE DAVIS

19a. Informant's Name/Relationship (Type, Print): RHONDA JENKINS (GRAND-DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6441 WOODGREEN CIRCLE, BALTO. MD. 21209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD. NATIONAL CEMETERY
Date: 06-13-02
20c. Location - City or Town, State: LAUREL, MARYLAND

21. Signature of Funeral Service Licensee: Cathy N. Williams
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD 21217

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cardiomyopathy — 10 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Peripheral vascular disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Pamela Ouyang MD
29c. License number: D23085
29d. Date signed (Month, Day, Year): June 12, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAMELA OUYANG, JOHNS HOPKINS BAYVIEW MEDICAL CENTER, 4940 EASTERN AVE, BALTO, MD 21224

**State Registrar**

31. Date filed (Month, Day, Year): JUN 13 2002
32. Registrar's Signature: Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

5

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 18998

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| CLARA | DOROTHY | WRZESINSKI | JUNE | 11, | 2002 | 7:30am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| FERNBROOKE 1190 MONIE DRIVE - NURSING HOME | ODENTON | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-40-0992 | 1☐M 2☒F | 91 Yrs. | | | MAR. 1, 1911 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | SEVERN | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1222 REECE ROAD | 21144 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| PAUL MILWICZ | JOSEPHINE KOSLOWSKI |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. BARBARA H. WADDILL (DAUGHTER) | 1305 DELVALE AVENUE, DUNDALK, MARYLAND 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | GLEN HAVEN MEMORIAL | June 17, 2002 PARK | GLEN BURNIE, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Stephanie Allen mousd | SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Stroke — 1 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Hypertension — 10 years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☑Other (Specify) Nursing Home

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Elliott Gorbaty MD | D2-0094 | 06/11/02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliott Gorbaty MD 7845 Oakwood Rd, Glen Burnie, MD 21061

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | ▶ B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2002 18999

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| LOTTIE WILMORE | JUNE 03 2002 | 7:40 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Maryland General Hospital | Baltimore City | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-03-6491 | 1☐ M 2☒ F | 99 Yrs. | | | Sept 25, 1902 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Randallstown | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3806 Collier Road | 21133 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| unk | unk | housekeeper | private residents |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| unk | unk |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joe Carni/caregiver | unk |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Colon Cancer

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| M Vasanthakumar MD | D 42510 | JUNE 03, 2002 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. VASANTHAKUMAR, 821 N. EUTAW ST SUIT 407, MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 13 2002 | Benjamin D Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospitel or Attending Physicien:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Lottie Wilmore

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2002 19000

NAME: Armiger, Lillian Anna

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Lillian Anna ARMIGER | JUNE 2, 2002 | 7:30 AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Reeders Memorial Home | Boonsboro | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 536-20-6650 | 1☐M 2☒F | 94 Yrs. | | | May 12, 1908 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Boonsboro | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 141 S. Main Street | 21713 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | Nurse | Hospital |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles H. Pope | Mary E. McConnell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Rosemond S. Coffin - Daughter | 127 Southern Oak Drive Hagerstown, Md. 21740 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Hill Crest Memorial Cemetery | June 5, 2002 | Annapolis, Md. |

21. Signature of Funeral Service Licensee ▶ Scott M Minnich

22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. probable cerebro-vascular accident | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D32518 | 6-2-02 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. ROBERT GUEDENET 21 WYAND DRIVE, KEEDYSVILLE, MD. 21756 / 301-432-2222

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JUN 04 2002 | Geneva G. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

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**To the Hospital or Attanding Physician:** The law requires that the death certificate be executed within 24 hours after death.
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